



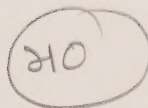


Digitized by the Internet Archive  
in 2022 with funding from  
University of Toronto

<https://archive.org/details/31761114671761>







S-66

S-66

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 12 September 1994

# Journal des débats (Hansard)

Lundi 12 septembre 1994

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

Long-Term Care Act, 1994

Loi de 1994 sur les soins  
de longue durée



Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

*1944–1994*

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 12 September 1994

Lundi 12 septembre 1994

*The committee met at 0906 in the Delta Hotel, Ottawa.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

LISE NOLET

**The Chair (Mr Charles Beer):** We have a very full schedule today here in Ottawa going through until later this evening, so we'll begin this morning's presentations. I invite Lise Nolet to come forward, please. Good morning and welcome to the committee. We have received a copy of your presentation, so when you're ready, please go ahead. We have 20 minutes.

**M<sup>me</sup> Lise Nolet :** Merci. Bonjour, mesdames et messieurs. Good morning, ladies and gentlemen. Je me nomme Lise Nolet. Je vous adresse la parole aujourd'hui non à titre de professionnelle des soins de la santé mais à titre d'une citoyenne intéressée au domaine, puis aussi à titre de la plus jeune membre du Conseil consultatif de l'Ontario sur la condition féminine.

Ma présentation est suite à une consultation avec quelques-unes de mes collègues au Conseil consultatif, et puis aussi d'intérêt personnel, puisque j'ai une sœur qui est atteinte d'une maladie assez grave et qui sans doute, ou probablement, devra avoir recours à vos services, peut-être plus tôt qu'on l'aimerait. J'ai aussi remarqué que c'est souvent une question d'implication ou d'intérêt spécifique pour les femmes, les soins de santé de longue durée. J'ai de même remarqué ceci en lisant votre politique. La majorité des ministres du cabinet qui étaient impliquées étaient des ministres femmes. Donc, c'est ça qui est la présentation d'aujourd'hui.

In principle, one cannot dispute being in favour of the proposed community-based long-term care model, because it establishes a long-awaited empowering quality care. The empowerment of communities and clients is an interesting aspect of this bill, and this I find is a very positive aspect.

There are some other positive points that I would like to point out to you from Bill 173: the fact that it strengthens viable alternatives to existing rigid health care regulatory systems; the fact that it wants to improve service quality at local levels through a flexible regulatory framework; the fact, as I have mentioned earlier, that it empowers communities and clients in their capacity as decision-makers and providers of services and also as consumers of health care services. It will facilitate an equitable access to services by various interest groups and

regions and it will guarantee an appropriate accountability by decentralized health care administrators.

However, as with other proposed programs, some flaws do exist and some questions remain unanswered. This is why I have decided to come forth today and do a presentation. My questions and the points that I want to raise to your attention today are of specific interest to women in Ontario.

In their diverse roles in society, women take part in long-term health care with their hearts and sometimes their lives. Clients are often women, who necessarily have different needs than men. The reason why women are often clients is because of their longer life expectancy and the fact that women make up the large majority of the family members who are caught in the middle between their work, their children, their ill partners, their ill and elderly parents and their ill children. Therefore, Bill 173 may raise some concerns for those women who work in and/or consume long-term health care services, such women as retired women caring for aging parents, disabled or ill partners, disabled or ill children:

—Local responsibilities delegated to municipalities may mean a lack of consistency among program delivery methods depending on the local district health council's priorities, therefore moulding the services according to the degrees of awareness of the region to women's special needs, as well as various regional practices in human resources management.

—Northern Ontario women and other rural regions in Ontario may be disadvantaged in the budget allocation model. Such reasons are for the travel costs, the isolation and the lack of qualified health care professionals to serve those designated areas.

—Some criteria may differ from region to region in organizing the waiting lists for services, again based on varying levels of women's needs awareness among regions.

—Special assistance in 24-hour care will be needed by disabled women who have children.

—Cutbacks to hospital jobs, which represent decent wages, good benefits and permanence: These will be replaced by community-based jobs, which will probably be for the most part contract-based jobs, depending on patient load, with little or no benefits or security. It should be noted that most of those health care professional jobs are held by women.

To approach the above issues, an appropriate understanding of real-life problems is needed to respond to women's concerns. The reform of long-term health care

legislation is particular in its span of impact. It will indeed affect the weakest members of our society—that is, the chronically ill and the elders—and will transfer their future into the hands of the communities in which they are part.

The various actors involved in this reform are in major part women. The roles, needs and benefits of women in Bill 173 are diverse but can be classified in various categories according to the functions women can play in the long-term health care system as clients, as taxpayers, as agency administrators and as health care workers. In each case a particular concern emerges, and history tells us that women's concerns, while being sometimes very different from men's agenda, are often obscured in such reforms due to the lack of awareness for women's special needs and roles in the health care system. One needs to admit that each region in Ontario differs in its degree of understanding and willingness to support women's special needs and roles and benefits in health care.

The decentralization of long-term care services may increase this segmentation of women's needs understanding. A major implication of this is that each agency and district council is free to interpret what women really need and what their role can be in providing long-term health care services. Moreover, the guarantees of proportional representation of women on administrative boards and in decision-making are virtually left to each agency and council, which increases the risk of lower awareness of women's needs and roles.

Because of their important involvement in the health care system, and because of their particular needs and constraints when becoming dependent on long-term health care, women do have a dramatically different agenda than men. The reform should in effect take this fact into consideration, since it may detrimentally affect the lives of quite more women than men, and this to quite different extents.

I understand that legislation, when passed, must be flexible enough to evolve with time passing by and avoid making references to the changing conditions of specific groups in society. Nevertheless, it should be possible to recognize seemingly stable patterns of gender relations behaviour in Ontario's regions and of the structure of female lives and work in the health care system.

The issues raised above are still at the stage of questions. It would require a certain amount of clarifications from professionals to guarantee that the responses to those concerns are positive for all women. I nevertheless attempt to point out a couple of such issues in detail here which make reference to specific sections of Bill 173; for example, when I discussed the waiting list issue earlier.

Bill 173 deals with the waiting list issue in subsection 21(2) by stating that the person in need of services will be placed on a waiting list if the service is not immediately available to him or her. But my question to you is how this list will be prioritized. Will this waiting list be based on a first-come, first-served basis of application, or will there be needs assessment to prioritize who is in greater need of these services?

For example, if a needs assessment is not conducted, a young mother with two young children who is disabled

with multiple sclerosis may be in great need of care for her children and for herself to keep going on a daily basis, but if she has been put on the waiting list later than someone who is not as severely handicapped or in as great need as she is, they may have services before her. That is why I feel that needs assessment should be conducted in order to prioritize waiting lists.

Another scenario: I am wondering if chronically ill or elderly people on a waiting list will be disadvantaged if they have informal care givers at home taking care of them. We should note that these informal care givers are often women who have to care for them. They are in great need of support also, and I'm wondering if these people will be disadvantaged.

On another issue, subsection 2(7) of Bill 173 deals with the professionals. It enumerates all the professionals that will be dealing with this new health care system—well, they have always been dealing with the health care system. These are all professions that are traditionally occupied by women. The caring and helping professions, as they are known, are not the highest paying professions, especially for female workers, and now if they become decentralized, they may even be less secure, with less benefits.

In conclusion, this evaluation of Bill 173 could continue for hours. In my quality of ordinary citizen, I may not afford this procedure. However, it is this Legislature's responsibility to recognize the special roles, needs and benefits of women in long-term health care reform.

We have pointed out earlier that the decentralization and empowerment of the system in providing these services will generate new possibilities for better administration of health care. But our statement of women's concerns and their particular perspective in the health care system should provide this committee with sufficient material for further analysis. I commend this Legislature to come up with clear statements and guarantees of women's particular needs, roles and benefits of Bill 173.

**Mrs Barbara Sullivan (Halton Centre):** Welcome to the committee. You're the first person who has come before the committee to specifically identify the particular concerns of women. I think that in one area, with respect to the waiting list, you've identified a problem that's a singular one with this legislation. The only guarantee, in fact, in this entire legislation about long-term care is that one will be put on a waiting list.

We know that in other circumstances, whether it's hospitals or waiting for services in other areas that are non-institutional, there are various methods of determining what kind of priority there would be. Sometimes it's geography, sometimes it's acuity, sometimes there is an examination of what the health and social needs are, and sometimes the waiting list is completely determined by service availability.

My deep concern with this legislation is that because the only guarantee is that there will be a waiting list, and secondly, there is no guarantee that funding will flow to the MSAs to provide the services, in fact the waiting list will be controlled by the fact that services simply aren't available in a community, and many of those agencies that have been providing those services will simply be

put out of business. I wonder if you'd comment on that. Have you considered, I guess, the issue that in fact the rationing will be done because the services won't be available?

**Ms Nolet:** Yes, but I was just wondering how the waiting list procedure will be conducted, if it will be on a first-come, first-served basis or if there will be needs assessment conducted to ensure that the people who are in great need of the service will be getting that service before other people who maybe are—well, we can't say that anyone is not in need of a service, but with the needs assessment, we can measure and identify special-needs people who are maybe in more urgent need. That is the point I wanted to make.

**Mrs Sullivan:** I understand that, and I think it's a very good one. The difficulty is that there's no criterion for establishing those waiting lists. The criterion is just that the waiting list be established. Thank you for making this point.

**The Chair:** Thank you very much. I regret that since there are a number of presentations today, we're limited with question time, but we appreciate your coming before the committee this morning.

0920

**Mr Larry O'Connor (Durham-York):** Can I make a point? We received today also some information by ministry officials on governance. In light of the information—it's really quite useful and practical—I wonder if we could have the clerk make additional copies so that we can pass one on to the people who make the presentations as they leave, because it does answer some very practical questions for these people.

**The Chair:** I think we can arrange that.

VICTORIAN ORDER OF NURSES:  
EASTERN COUNTIES BRANCH,  
PEMBROKE BRANCH,  
OTTAWA-CARLETON BRANCH,  
SOUTH RENFREW BRANCH

**The Chair:** I call the Victorian Order of Nurses: Eastern Counties, Ottawa-Carleton, Pembroke and south Renfrew Branches. I would just note to committee members that as we have done on a number of occasions with the VON, they have come together to make a joint presentation, which is the reason for there being more time. Depending on how that time goes, I will work in one or more questions.

Ladies and gentlemen, welcome to the committee.

**Ms Beth McDonald:** Good morning. On behalf of the Victorian Order of Nurses, Eastern Counties, Pembroke, Ottawa-Carleton and south Renfrew branches, we're pleased to come before the Ontario Legislature's standing committee on social development to share with you a joint perspective from the areas served by our branches. The members of VON representing the branches are Charles Armstrong, president, VON Ottawa-Carleton branch; Joan Booth, president of VON, south Renfrew branch; and Beth McDonald, executive director, VON, Ottawa-Carleton branch.

At the outset, we commend the government for demonstrating ongoing commitment to involving stakeholders—

volunteers, consumers, service providers and others from across the province—in this process of health care reform. Again today, you have shown your willingness to consult with the people through your visit to this region and your invitation to the VON to present before you.

Our paper, which has been circulated to you, gives a brief overview of who we are, followed by areas of the legislation VON endorses as well as our key areas of concern and recommended revisions to Bill 173.

For the purposes of this presentation, highlights of our brief will be presented. We will hear first from Joan Booth, president of south Renfrew branch.

**Mrs Joan Booth:** Thank you for the opportunity to present to you. As a volunteer, I wish to begin by addressing the planning document, A New Way to Plan, Manage and Deliver Services and Community Support.

On page 4 of the partnerships document we read, "Ontario has a number of excellent long-term care and support programs that provide a wide array of services."

To take over everything which you acknowledge to be excellent because there are a few flaws and limitations would be one of the most paternalistic approaches possible. Surely a more mature and democratic approach would be to offer help and constructive guidance. Democracy is more about growth, independence and ultimately interdependence than about control, power and take-over. In the 19th century, Abraham Lincoln summed it up in the words, "As I will not be a slave, I will not be a master."

Another quote from the document: "Neighbourhood and other groups have made significant contributions to supporting members of their communities by developing community support services, with volunteers in many instances playing an essential role in the provision of these services."

Here, may I add, volunteers have played an essential role in the initiation of many of the services too. As a volunteer, I helped build, deliver and fund-raise for many of the support services and programs available today. Like many others, I volunteered because it's a way of life. Volunteering is giving from the heart, just one of life's responses to life's knocks, opportunities and experiences. In an age of designer labels, it seems only what is bought or paid for has value or respect and anything given freely has no worth and is even suspect.

Another quote from the document: "The MSA plan must include an employee transition plan outlining: volunteer responsibilities and recruitment and retention strategies...."

This plan to actively recruit, train and retain volunteers is a misuse of the term "volunteer." Volunteering grew one person at a time. Now these persons are perceived as a group. Such collective nouns when referring to individuals suggest someone seeks to manage and control. In this context, volunteers as employees, unpaid workers, might more aptly describe the intent. However, since workers have benefits, remunerations, rights and protection, it would be equally incorrect to use that term.

Another quote from the document: "Volunteers will be needed.... Fund-raising, promotional and public education

activities, so ably carried out by many volunteers now, will continue to be essential in the MSA."

Thousands, perhaps millions of hours of unpaid work will certainly be needed, along with hundreds of private vehicles, to make the government big MSAs work and to fill the gaps which will be created by the dissolution of agencies, early hospital discharges and an aging population. Throughout the reform process, it does not appear that quality of service is being challenged, rather the affordability of agency boards.

Another quote from the document: "Board members are volunteers. In most agencies, board meetings and related activities require much time and energy."

Have board members complained? No. They are volunteers, free to resign if they find the commitment too onerous. How the amalgamation of agency boards into one big MSA and the setting up of new administrative bureaucracies will be more cost-effective is very unclear.

Another quote from the document: "With the amalgamation of boards, some board members may want to participate in other areas of interest, such as direct client service, or projects which support the service operations."

Many board members already do this in their communities in a variety of ways. The plan to dissolve agency boards at the time that boards have evolved to boards of governance developing a team approach to the service delivery by the agencies seems very negative.

Another quote from the document: "Communities can ensure some services do not lose their individual identities as they become part of a larger MSA organization, especially if this individuality is important to consumers. Through the use of such identifiers as a service name, logo or service location, these once separate service providers whose boards have amalgamated within the MSA can retain their individuality."

#### 0930

How is this possible? A logo or name are as much an integral part of an agency being a corporation as is its board. Perhaps more disturbing is the implied deception that the agency is still in existence.

The big MSA is about amalgamation of service providers; dissolution of agency boards; deployment of employees, paid and unpaid; a monopoly of hiring, planning, service delivery, monitoring, budgeting, funding and evaluating: about control and takeover. Is that what a consumer expected?

As a person needing one of the services, the greatest concern is clause 21(2) of Bill 173, "If a community service outlined in a person's plan of service is not immediately available, the approved agency shall place the person on the waiting list for that service and shall advise the person when the service becomes available."

A great deal of time has been spent on improving access to the basket of services, which is commendable, but will there be adequate funds to fill the basket, replenish the basket, pay for the new costly administration of big MSAs, remunerate all the employees who will be needed in the community on an equitable basis, for example, for transportation, including the additional persons who will be needed with hospital bed closures,

facility beds limited and more persons scattered in the community? Even employees labelled volunteers will have to get to where they have to go. With no cost analysis, the improved access could translate into access to waiting lists. The anxiety, confusion and now disillusionment are becoming as contagious as fear, hardly a recipe for health and wellness.

District health councils are making a gallant effort to comply with ministry direction in order to qualify for one-time funding in November. They are planning as if the MSA of clause 11(1) of Bill 173 had already been mandated, not for a bill still to be debated and not yet law.

Our recommendations: Produce legislation which will concentrate on access; streamline information and referral, eligibility and assessment by developing generic forms; increase use of technology for information management and exchange of data; plan for a continuum of care; make it possible for agencies to work more collaboratively by bringing together approved member agencies in a federation, conglomerate, consortium or even association, like a good United Way has an association of member agencies to reduce duplication and fragmentation; and please, handle our tax dollars with the same care and accountability as the United Way agencies handle our donated dollars.

We have to pay our taxes and put the money in your hands. We have no choice. But we do have a choice whether or not we give to help our communities. Please respect the ways in which we choose to give and leave volunteering in our hands.

As partners in long-term care, we are requesting a renewed way to plan, manage and deliver services with community support. Preserve what is valuable, fixing only what needs fixing, so the legislation may become truly an act respecting long-term care.

**Mr Charles Armstrong:** As we approached this topic, I tried to reassure myself—and continue to do so—as I made my notes that we were not approaching this—I was not approaching this and VON in the province of Ontario was not approaching this—as an emotional question. There's no doubt that when the concepts were first dealt with in policy papers, it was a very emotional time as we dwelt on our past and questioned where our future would be. I know as a branch we've gone beyond that and I hope our comments and our paper today really deal with a thoughtful, professional approach to long-term care in Ontario. That's the approach I believe we are taking.

As I made my notes, I said this is probably more a political process than an emotional one, and I somehow felt if we could remove the emotion in the politics, we could all go home and get the job done. There's no doubt that if we fail at this, the emotion on the streets will be quite real, as health care is one of the most fundamental services that the province does provide. As an accountant, I think we're always looking at the downside, and that's a real concern.

VON, among the branches that are here today, without question—there's no uncertainty—accepts the objectives of long-term care and the reform: the coordinated

approach, the consumers, the ease of access and being in the community. Albeit they're rather vague and imprecise, they are worthy objectives to work towards, and I'll explain that further.

Ontario should be proud of what we do have. We do have very strong community health care and long-term care. It's probably the success of what we have that's bringing us together at this time in that we are concerned about costs, and it's the success of what we have that's part of that problem.

If I look at our community and look at the players in this community, and I'm sure in many of the communities, we have strong players. We have knowledgeable professionals within the DHC, within the home care program, within the community groups. I have no doubt that within those groups there is the knowledge, the history, the experience, the professional training to work towards and solve some of the things that we're trying to solve here in the consumer-friendly and ease of access.

My concern, and this is probably quite personal, is that over the last period of time we've moved from one policy statement—we had a range of colours—and one policy paper to another, sat at board tables and tried to interpret what was being addressed, what did this mean, where are we going. We always say, "Well, there's not sufficient detail; there's not enough information to really know how to interpret this." And all of a sudden, we've jumped from those policy papers to proposed law.

As we sit in the community, we're very concerned as a branch. There's not sufficient costing, there's not sufficient detail and analysis to have the confidence that we really know what we're doing. My concern is that we haven't done the costing, we're not sure what this is going to cost to do, and yet we are comparing those costs to what we're trying to achieve, what we're trying to save.

Once we unravel what we have, I'm not sure we can put it back together that quickly. The Canadian Broadcasting Corp, some people within the corporation, decided that the news should change from 10 to 9—and I'm sure that wasn't broadly accepted within the corporation—turned out to be wrong, and it's not that hard finally to change the news back to 10 o'clock. This won't be that easy to put back if we go too far.

In thinking of what is happening in many provinces, in fact in many countries, there is definitely a move to privatization and to break up into smaller component parts, and perhaps that's exactly what the province is doing, but from the community's point of view, we're doing the opposite. We have the potential to go from free-standing groups to an amalgamated concept. If you read all the management books these days, the whole new theme, and we change the themes on a monthly basis, I think, but the focus now is on team playing. All the new books are on teams and objectives and hit squads and all that kind of thing, and I'm not sure that this is moving in the right direction there.

As I sit and try and say, "What are we trying to achieve?" I believe cost-effectiveness is one of the objectives, apart from the consumer focus, which means we are going to have to have, and I believe there's a

belief that we're going to have, fewer employees. They'll probably be middle-management-type people, which is happening all across the country in all kinds of industries. I believe there's a belief that we're going to reduce the overhead costs, and I'm sure there's a belief we're going to try to quantify the amount of product or reduce the amount of product that's available to be consumed.

#### 0940

We haven't seen those costs. I have no idea what the financial targets are. If we knew that, if you knew that, then the next question would be, is there another way we could save those costs or achieve those savings, and are they even meaningful targets? There's definitely going to be a cost to put this together, and I don't know what that cost is compared to the savings.

One cost that is not talked about enough—we're certainly talking about it—is the cost to close community groups. We've got commitments, we've got equipment and most of all we've got people. If there's job loss through this transition, there are certain laws that have to be upheld and people need to be paid, and there's going to be a major cost if there's a major downsizing in personnel.

Thinking about an MSA in the community, I think you see it as a community group with volunteers. At least at this stage, the community sees it as an imposed arm of the province with a bureaucratic flavour to it. I'm convinced that the MSA will be more bureaucratic, with more management people than most of the community groups. I look at our branch in Ottawa. It's a \$12-million-plus operation, and if we took out our staff who were involved with front-line people, we'd probably have two or three management people. The MSA will not be like that, I guarantee you.

I'm perhaps embarrassed to make the next point, but I have confidence that if you compare our salary costs to what your salary costs are going to be, there's going to be a gap and I think our staff will be happy because they're going to get increased salaries. So that's a plus from that point of view.

If you compare the dedication of our salaried staff in a voluntary organization with a history and a sense of team play and a purpose with a municipally run or a broader organization, I'm not sure the same dedication, the same donated time will be there. It's just a concern.

I guess the last comment in that theme is, who's on the street Friday night at 5 o'clock? Whom do you phone if you need help? It's the community groups in most cases. You don't try to phone a department of health after 5 o'clock.

On the financial side, I can assure the committee that within the branches, our branch in particular, we would donate, we would contribute to the program, your program, on an annual basis \$50,000 to \$200,000 or \$300,000 in terms of training, education; funds we don't receive as part of our fee structure, money that we raise to train staff as the mix of clients we receive changes. As we get pressured to reduce our fees, with a heavy investment in computerization, retraining, those are real dollars multiplied across all the community groups. I guess I'm

predicting those dollars will not be there.

Our goal: Regardless of what happens, we will continue on. VON will exist. We will be fund-raising for our own self and carrying on. I'm concerned that that drying up of funds is real, and huge dollars.

I guess our recommendation is, remain as flexible as you can. Nobody has a model in mind that they have confidence in. I've talked to countless people within the Ministry of Health, within the colleges and the universities and various agencies. Everyone has their own theory. Everyone believes they have a model that works, and "What's wrong with the other person's model?"

If we're not really sure, then I suggest we take a medical approach or a scientific approach: When you're not sure you just don't go and do it. You start small, you experiment, you test, you do a prototype in part of the province. The downside—it's too big. Many of the professionals are saying, "We're looking at the community health care and long-term care," which is a small part of the total health care scene. I'm sure that's next and it makes sense to do this part before we look at the whole thing.

The province's role I believe is to set the goals, objectives, the policy, the direction, which is being done. The province should be providing encouragement and support, which it's doing. That support also has to be financial support. The province needs to monitor, follow up, make sure that this policy gets implemented. But I really believe that until we know what we're doing we should go slow, we should let the professionals in the health care field tackle this thing, probably on a project-type basis, and above all, if we could go ahead without the emotion and without the politics, I think the consumer in Ontario would be the best served.

**Ms McDonald:** Having heard those comments, VON recommends the following areas be considered for revision in the act:

Greater flexibility in the model for consumer access to services. Given the diversity of Ontario in terms of geography and present service availability, the legislation needs to recognize unique challenges and dimensions to service delivery. The focus should be on ensuring mandatory services are accessible and protected, avoiding the bureaucratizing of the multiservice agency and ensuring the communities' flexibility to design the MSA appropriate to their needs. The development of provincial standards for delivery, monitoring and evaluation of those mandatory services, assuring consumer choice, guaranteeing adequate funding to meet consumer needs and the ability to mandate alternate MSA delivery models if objectives of long-term care reform are not achieved will ensure the purposes of the act while allowing the needed flexibility.

Protection of workers, regardless of affiliation to bargaining units, in the event of agency mergers. If the model for an MSA that evolves is one that includes the merger of existing agencies, VON urges the government to consider the needs for all employees in terms of fair and equitable opportunity for employment in the MSA. Such protection should be afforded to staff regardless of affiliation with unions. Employees represented by bar-

gaining agents have been afforded protection through the successor rights under the Labour Relations Act. Similar protection should be afforded to non-union workers affected by mergers in a multiservice agency. VON recommends that the legislation be amended to contain a clear statement to this effect in order to provide for equal opportunity for all employees accessing jobs in the MSA.

Stated protection in the act for severances and other liabilities. In the event mergers result in severance of workers and other outstanding liabilities, such as with property or dissolution of corporations, the government should provide funding to offset these costs. Presently, not-for-profit agencies which deliver a vast majority of community-based services do not have the resources to pay severance. In VON, surplus moneys have been returned to the government or reinvested in the community to enhance service delivery.

Stated preference for a not-for-profit registered charitable organization as a sponsor for the fully integrated MSA. The government has recognized that many charitable organizations are supported through donations and other sources of funding, such as United Way. Tax receipts are provided to donors and are an incentive to the donor. In order to ensure that much-needed contributions to charitable organizations continue, the MSA must be a charitable agency.

Building on existing skills and experiences. VON strongly believes in building on the existing skills and experiences already in the community. Such system is characterized by highly regarded health and community support agencies, volunteer commitment to and identification with these agencies and the charitable not-for-profit service offered, in addition to government-funded services.

The challenge is to achieve redirection goals building on the solid foundation in place today. VON proposes consideration of transitional planning for the MSA model consisting of a coalition of existing health and social service agencies. In listening to consumers, communities, health and social service providers and health planners, VON has concluded that there is strong support for the redirection goals of easier access to comprehensive and expanded services in the home and community.

#### 0950

VON is a respected cohesive organization in which all members of the board, staff and volunteers are committed to realizing the vision of health care for the province of Ontario. VON believes that the valuable skills, experience and innovation of all community-based agencies that for many years have made significant contributions to communities should be recognized, respected and further promoted.

Change must be well planned and integrate the strengths of the current service system. The guiding principles of long-term care parallel VON's core values and fundamental philosophy. VON is committed to providing leadership through the transformation of our health and social services system.

Mr Chairman, this concludes our formal presentation.

**The Chair:** Thank you again for coming together in

a joint presentation, which gives us a little bit more time for questions, and we'll begin with Mr Wilson.

**Mr Jim Wilson (Simcoe West):** Thank you for your presentation. It was very comprehensive and in fact covered a number of concerns that we've also expressed in our PC caucus in terms of the approach that this bill is taking to the principles. I want to ask you about that. In group after group, when we were holding public meetings for a couple of weeks, we heard many concerns, and I think the bottom line is, should we be supporting this legislation? We all know the principles. We have great concerns, though, as to what this government has done with the principles of long-term care.

Somewhere along the line in those rainbow-coloured documents we went from one-stop shopping or access, which I thought—as Health critic for a number of years I followed it and participated in many of those public consultations—in the legislature was going to be a fairly simple model, one phone number in an area. I didn't think we were going to have this sort of monopoly MSA, as Ms Booth has correctly pointed out. I didn't hear a great outcry from the people of Ontario that they wanted MSAs to not only coordinate the services but also to have a monopoly on delivery of services.

I have two questions. One is, is it worth it, given this legislation and given that as legislators we have a very clear yes/no decision to make to this legislation? Secondly, I do want to know: Given what the bill actually does, aside from the principles of long-term care which are stated in all kinds of wonderful documents, will the people of eastern Ontario benefit in any way? My belief is that much of the money that's to go to long-term care will not be going to front-line services but will simply be spent in the next few years setting up this monopoly.

Do you want to tackle those? We're getting down to the wire here and we have to start to make some very serious decisions on how much opposition we want to put forward to this bill.

**Ms McDonald:** I think you've heard from us the areas where we have some concerns and you've certainly re-articulated those. The principles of the bill, the purposes and the goals, I think are sound. How it has moved over the past four years from improving access through information and referral to this now potentially very large, expensive bureaucratic system is very difficult to understand, and obviously we're suggesting that it not be supported.

**Mr Jim Wilson:** That's very clear. Thank you. Mr Armstrong, I think, wants to say something.

**Mr Armstrong:** Yes. There's no one involved in health care that would not suggest there are ways to improve, to cut back on costs. I think all the players know there are savings to be achieved and there definitely is duplication of management functions, if you look at the community, and an MSA in some form of concept will deal with that.

It can be dealt with. If that's an objective that we need to solve, personally I believe it can be solved in a much easier and less dramatic way, a way with less potential downside than the coming together in some huge con-

glomeration. We can't do it without knowing more about it and that's the biggest fear. That's the message, I think.

**Mr Jim Wilson:** I think you're right on the pilot projects, and that would be the commonsense way to approach this, I would think.

**Ms Jenny Carter (Peterborough):** I'm just looking at the question of governance here. You talk about a bureaucracy, that somehow we're establishing a bureaucracy by bringing these different organizations together. I have in front of me a document that is discussing this question of governance of multiservice agencies. They'll be governed by independent community-based boards of non-profit corporations which will be elected and will hire their own staff. It's not the ministry's intention to appoint these boards, nor to hire the staff of the MSAs.

Also, we have provisions that at least one third of the members of the boards be consumers and that there should also be providers represented on those boards. There is a suggested definition of "consumer" here, which is "someone with physical disabilities, someone who is or has received long-term care services, family members of someone receiving LTC services, family care givers and parents of children who receive or have received school health support services."

This doesn't sound to me like a bureaucracy, so I just wonder what your comments on that might be.

**Mr Armstrong:** Certainly my comment is that I don't think the board is going to be bureaucratic. I'm not sure I can see it evolving in the traditional community sense off the bat, but it's not the board that's going to be bureaucratic; it's the structure itself which is going to have numerous employees and numerous activities. Reading the law, as soon as we start drafting law, it gets bureaucratic in who gets access and what are the tests.

**Ms Carter:** But it seems to me that by simplifying it we're making it less bureaucratic. There are going to be fewer people employed at that level of management and more people in the front lines actually providing services to the consumer.

**Ms McDonald:** Our position is that with the present systems that involve community agencies as providers, in fact we are very streamlined presently. Part of our concern relates also then to the cost and the lack of costing. We don't know what the expected outcomes are. We hear cost-effectiveness. How do you measure that? What services are going to be mandatory? What are not? The question was raised earlier by Ms Sullivan, how do we deal with waiting lists? People are not on waiting lists, by and large, these days. What happens to the basket of services, as Mrs Booth asked? What's in the basket? We don't know that yet, and until that kind of information is available, we don't believe that good planning and implementation can be done and achieve a goal or the goals of improved health care, which I think is what we all want.

1000

**The Chair:** We could go on for the rest of the morning, I'm sure, with questions, but we thank you very much for coming before the committee with your presentation today.

OTTAWA-CARLETON  
COMMUNITY HEALTH CENTRES

**The Chair:** I then call upon the representatives of the Ottawa-Carleton Community Health Centres. Welcome to the committee. I should probably add that I noticed one of your members has been very helpful in answering the telephone that's been ringing at the back and delivering messages to the front. What will happen now that you're up here I'm not quite sure. We want to thank you all for coming this morning. We have a copy of your presentation. If you'd be good enough to introduce yourselves, please go ahead.

**Ms Martha Smith:** I'd like to say good morning to the members of the standing committee and thank you to the audience behind us for coming. We're here to represent the network of community health centres in Ottawa-Carleton. With me are David Hole, the executive director of South-East Ottawa Community Services; Karen Stotsky, the executive director of Centretown Community Health Centre; and Peggy Feltmate, the executive director of the Community Resource Centre of Goulbourn, Kanata and West Carleton. My name is Martha Smith. I'm a program manager of senior services and I'm also from South-East Ottawa Community Services.

We're here to represent the network of community health centres which right now numbers seven in the Ottawa-Carleton area. We're serving a number of communities—Sandy Hill, Centretown, Somerset West, south-east Ottawa, Pinecrest-Queensway, Carlington, Goulbourn, Kanata and West Carleton. Currently, we number about 350 staff jointly and administer \$18 million in community and public funds. In the past year we've had 800 volunteers, approximately, who have been offering about 55,000 hours of volunteer service.

We are multiservice centres made up of multidisciplinary teams of professional staff working in two areas: social services and health services. The focus of the centres is on the integration of health services and social services. The services are developed in close consultation with the most vulnerable populations in the neighbourhoods that we serve and each health centre has its own defined catchment area serving unique populations.

The reason why we're here today is that we work closely with those who will be affected by Bill 173, and we have a vested interest in ensuring that with the new reform system it will meet their needs. We have a perspective on community services that we believe is useful in the further development of long-term care reform.

Community health centres are unique in the Ontario health care system. We promote good health and illness prevention. We're committed to providing accessible services, especially to the higher at-risk population in our area. We empower individuals and communities to take charge of their health, therefore we're very involved in both social action and community development and they're integrated into our service delivery system.

Consumers are part of both our planning and our operations. The teams work together with clients to address the whole range of their needs, including physical, social, emotional and the financial needs of our consumers. We

have many years of expertise and experience which we want to share with you in the next few minutes.

Now Karen Stotsky will tell you about our views on multiservice agencies.

**Ms Karen Stotsky:** We've decided to focus our presentation in our short time today on some of the characteristics that we would hope would be enshrined in multiservice organizations, since they are really a central plank of the reform strategy, and then we'll spend a few minutes talking about some of our concerns around the legislation as well.

With respect to the multiservice agencies, their importance in the legislation cannot be overstated. The purpose, as expressed in the legislation, is to address access and continuity of care, to increase the responsiveness to consumer needs and to the community at large, to streamline the accountability of the board structure and to make a significant consumer and care giver representation.

These are features that, as community health centres, we've had embodied in our organizations for quite some time. We would like to list for you some of the functions we would like to see enshrined in the MSA structures as they're developed. We've divided our comments into several different areas.

The first one has to do with the organizational structure of the MSAs. It's our hope that the organizational structure of the MSA would be done in such a way that there would be an emphasis on information sharing, collaboration and participatory decision-making. We'd like to see a fairly flat horizontal management structure, a team approach, a commitment to ongoing staff development and a commitment to defining appropriately sized catchment areas that would foster community ownership and strengthen community participation.

With respect to governance of the MSAs, we'd like to see a community-driven organization with non-profit community boards and committees; staff representation on the board to enhance the contribution of the staff; and a commitment to enable neighbourhoods to act on their own behalf.

Speaking on the point of staff representation on the board, some of the community health centres currently have staff representations on the board. Some are voting and some are not voting. What we've found is that with staff on the board it does make a difference; staff have a voice. It helps to feel ownership to the services that are provided and to the policies that are developed.

There is a stake in having the community perceive us as having a stake in the organization and, in addition, another feature is that it creates a more open environment in the organization.

With respect to dynamics of service delivery, we'd like to see a multidisciplinary approach to care and flexibility to consumer needs.

Strong links with community and colleagues is another feature that we think needs to be included, and the availability of a user-friendly appeal process that involves the consumer that's timely and appropriate.

Linked very closely to the dynamics of service delivery is the issue of consumer and community participation,

and we'd like to see an organization that creates opportunities for meaningful consumer participation and that has a commitment to community development. By community development, we mean working with the community to enable them to take more control over issues that are important to them and to work with the community where they're at.

Just as an example of one of the kinds of health promotion community development initiatives that has been undertaken in our area recently, a large bureaucracy introduced the concept of a Communibus which defined a route throughout our area without very much community consultation. In the end it was quite apparent that the route that was chosen was not very accessible to seniors. One of the things we did as an organization was work with the seniors in our neighbourhood to organize them to go to a meeting, raise their concerns and make recommendations. With the involvement of seniors and seniors taking some control over the issue, there were some changes that were made.

We'd like to see a commitment of the MSAs to do some work in the area of health promotion and community development so that there is a greater identification with the community. We'd also like to ensure that the community and consumer participation is both meaningful and dynamic in that the structure is organized in such a way that this can be possible.

The other point we wanted to emphasize was the role of volunteers; not only their importance, the importance of volunteers in a neighbourhood-based agency, but also the importance of putting a coordination role in place so that volunteers can be trained, oriented and do work that is meaningful to them. David will be speaking more about the role of volunteers when we speak about our concerns.

**Mr David Hole:** With that intro on the role of volunteers, I just wanted to comment briefly on the Chair's recognition of my telephone reception skills at the back. It seems to me it's just a further demonstration that no matter how well organized the endeavour, the role of volunteers can never really be underestimated. I'll come back to volunteers further later on in the presentation.

One of the first points we wanted to make have to do with the issue of integration as opposed to amalgamation. It seems to us that in many of the discussion papers and other consultation things that came through the system in the development of this legislation, the notion of integration of services was very much more highly featured and evident than seems to be in Bill 173. It seems to us that most of the direction of the legislation seems to be favouring the notion of amalgamation of a whole variety of community organizations and agencies rather than facilitating integration of those agencies.

In South-East Ottawa Community Services I can't pretend that we're typical of community health centres in the province, but we're certainly not unusual in that we've placed a high emphasis on integrating programs and services. Although we're funded as a community health centre, we receive funds from the long-term care branch to administer community support programs for the elderly and, as well, we've integrated programs of visiting home-

maker services from the regional municipality social services department, so we're able to provide an integrated and coordinated model of programming for the people in southeast Ottawa. Although there are many points of access to the populations in southeast Ottawa there is, none the less, a one-stop kind of service for people, particularly the elderly, requiring those kinds of things.

Similarly, we're physically located in an elderly persons' centre, an EPC, which means that people who are receiving home care programs, home support programs, and community health programs for the elderly can also very readily access cultural and recreational programs in the same facility.

#### 1010

In short, I think you'll find the community health centres and community resource centres in Ottawa-Carleton can provide viable models for integration and that the strength of integration means that those agencies that are contributing their resources and their staff are able to maintain their mandate and bring added strength to the organization that is integrating, whether it's a multiservice centre or some other organization.

A second concern we have relates to health promotion and wellness. Again, we were pleased to see those concepts introduced. What we're not clear from Bill 173 is just where health promotion fits and where wellness fits as concept in the range of services and programs that are proposed. In particular, it seems to us that the model most highly touted is one of case management. While we agree that there's a need for strongly coordinated assessment program no matter where people are destined in the service spectrum, it seems to us that case management and identification of needs doesn't necessarily lend itself to wellness programs.

Health promotion may well identify a need for breaking down social isolation for senior persons who are otherwise fairly isolated in their homes. A prescription of participation in an activity group or a bridge class hardly seems appropriate for a case management kind of model. We would encourage a review of the predominant case management model which we think is much more highly medically modelled by us to something that is somewhat more sympathetic to social approaches.

Building on that theme, we're concerned too about the place that social services will have under long-term care reform. It seems to me there's a genuine risk that social services professions will likely be shoehorned into more of a medical model of service delivery. The challenge here is the integration once again of health and social services and not the assimilation of social services by health professionals and health models.

A question we have is that we're not really entirely clear about the thinking behind the establishment of a fee structure for "social services" but not for "health services." We are pleased to see that health services remain universally accessible and there's no barrier imposed by a fee structure. But if the genuine intent of Bill 173 is to secure the integration of health and social services, it seems to me that this is a structural impediment to that. It seems inconsistent with one of the thrusts here.

Another concern of ours has to do with community approaches. Throughout our presentation there's been an emphasis on community and community development and community direction. One weakness of the legislation is that there's no clear definition of what the government means by community. We certainly know what we mean by it. It has to do with neighbours helping neighbours. It's very much a peer support kind of thing and people knowing one another and caring about one another. This requires a certain economy of scale and a retention of human scale.

We're concerned that, if we are genuinely going to be valuing community control of planning and management and service delivery, multiservice agencies and the other instruments for long-term care reform need to be locally based, which means they need to cover fairly small areas of population or communities of interest that are secure in their identity.

Our other concern, of course, is that this is a bill designed to marry the community services sector with the home care sector to deliver comprehensive services. The relative sizes of these two sectors suggest an inequality of power and influence. When one rolls over the other one is likely to squeak pretty loudly. I'm reminded of a Woody Allen comment that, "The lion and the lamb shall lie down together, but the lamb won't get much sleep." In this case, I'm not convinced that the community service sector is going to be getting a whole lot of sleep in this particular marriage.

In relation to the use of volunteers, to return to this theme again, aside from the value that volunteers bring to community enterprises like this—and I'm hoping this remains a community enterprise—it seems to me that the volunteers themselves experience an increase in their own quality of life because of what it is they're able to give back. A number of our volunteers speak of it in those terms, giving back to the community, and we want to ensure that whatever system evolves here will continue to provide a place for volunteers.

Finally, in relation to district health councils, we work very closely with the local district health council. There's considerable reference made in Bill 173 as to the continuing role. We would like to ensure that the district health council remains as much a local resource and an autonomous local resource that's in a position to continue an advisory role to the ministry. There are some concerns that some elements of this legislation may co-opt a lot of the independence and autonomy of the local district health council.

We want to ensure essentially that everything about Bill 173 ensures that control of these particular services remains at the local level, ie at the Ottawa-Carleton level. This relates too to the appeal process, and it's some concern to us that if there are consumers who are unhappy with either the range of services provided or the way in which those services are provided, apparently the appeal process takes it away from the local level to some sort of provincial appeals board and I must confess I'm a little perturbed by that. It's hard to understand how control stays local when any concerns with the local service delivery are dealt with at a provincial level. It

seems to me that the level of an appeals board might do better to deal with more policy level concerns rather than service delivery concerns.

I wanted to ensure some opportunity for dialogue since that's an important part of this process and I hope there's still some time left.

**Ms Evelyn Gigantes (Ottawa Centre):** I'd like to thank you very much for your presentation and for the reminder that you give us as we consider this legislation about the importance of community involvement in the decision-making process, and also the importance of services which are not of the medical model in maintaining people's health and welfare in the community.

The one question I'd like to raise with you is the question of assessment. One of the earlier delegations had raised with us the notion that we should leave organizations providing service in the community currently, in particular the VON in this case, to do their own assessment. I'd like some comment from you, if I could, about the practicality of having various assessment processes involved in an integrated long-term care planning process and delivery of service process, and whether we can make any judgements about how effectively we can organize overall service delivery to the community from the existing patient placement services at the community level.

I'm very curious about what your experience is and what your thoughts are in this area.

**Ms Smith:** I have one response, and I know the group after us will also be talking about that. I have no problem with there being standardized assessment, but I think at different levels. For example, in our agency we might have 300 seniors this winter who call us and only want snow removal. To go and do an assessment to the same extent for someone who wants, say, respite care or bereavement support—it would just not make sense to do the same type of assessment.

I do agree, though, that among the agencies, to standardize them would be an improvement. However, I think it should be level appropriate.

**Ms Gigantes:** There was one other comment coming, I think.

**Ms Peggy Feltmate:** I was going to say I think, as well, with assessment, that the standardizing and the training becomes really important to ensure that all the aspects are taken into account. I guess my fear would be to lose both the social aspects that are required to the strictly health and medical.

**Ms Gigantes:** It relates to case management too, as you raised it.

1020

**Mrs Yvonne O'Neill (Ottawa-Rideau):** There's so much about your brief I'd like to comment on. I'm particularly happy that you mentioned the appeals being taken from the local level and the amalgamation versus the integration. My question: You talked a little bit about the DHC. I'd like to know if you are involved in the long-term care process here. Do you see yourself becoming an MSA? I certainly personally think that's very viable. Finally, if you could just say a little more about

your very brief comment about the 20% cap, I'd like to get that on the record.

**Mr Hole:** I'm prepared to respond here, with some trepidation, because there isn't agreement among all community health centres on this point. With regard to MSAs, we are multiservice agencies, small M, small S, small A, and that's our *modus operandi* right now.

With regard to whether community health centres could and should function as sponsoring organizations for MSAs, all of our organizations are presently community directed and controlled. We're all very separate, very autonomous, and our intent is to meet the needs of the neighbourhoods that we serve. Ultimately, it would be a choice of particular community boards.

As I say, there is no universal agreement as to whether it's desirable for community health centres to take on the role of MSAs. I can tell you there's some interest in southeast Ottawa, but I don't know how typical that is of community health centres.

In relation to our involvement with long-term care planning locally at the DHC, we have some representation on the MSA working group, and we're also represented—we actually come from two streams of service delivery, community support services as well as community health services, and we have some indirect representation on the long-term care committee, meaning that these aren't community health centre reps *per se*, but none the less people with whom we maintain a close liaison and ensure our voice is heard there as best we can.

**Mrs O'Neill:** Have you got the 20%? Can you say that?

**Mr Hole:** Yes, with the 20% thing, our brief suggests that we could live with that, if it has to be included, if it was administered on a global basis in the program budget rather than on a category-by-category thing. Obviously, our concern is that with any kind of restriction on the amount of purchasing of service that's available under an MSA would mean it's more likely to be an amalgamating kind of model rather than something that would facilitate integration.

My sense is that the intent is to ensure that more and more services are in the non-profit sector, and that's what's behind this cap. If that's so, then ensure that the cap relates to private sector organizations. My interest and concern would be to ensure that those non-profit organizations that have really strong roots in their local communities aren't going to be decapitated by this. They just won't be able to remain effective or be allowed to integrate their services into a structure that's designed to improve access.

**The Chair:** Thank you very much again. We could spend much more time on questions, but I'm afraid we're going to have to move on.

**Mr Jim Wilson:** Mr Chairman, while the next group is coming forward, could I just pose a question, please?

I was wondering if the parliamentary assistant had available for the committee members a response to the request for the breakdown of the funding for long-term care. It's been mentioned by the government many times that a figure of \$850 million is money to be directed into

long-term care, and committee members have asked for a breakdown of that. We want to know how much of that will be new user fees and how much of it is actually new money. That request is some four weeks or five weeks old, I would think.

**Mr Paul Wessinger (Simcoe Centre):** Yes, I understand that information is likely to be available tomorrow.

#### COMMUNITY SUPPORT COALITION OF OTTAWA-CARLETON

**The Chair:** I then call on the Community Support coalition of Ottawa-Carleton. Welcome, both, to the committee and we have a copy of your presentation. If you'd be good enough to introduce yourselves, then please go ahead.

**Ms Ginette Rashleigh:** My name is Ginette Rashleigh. I'm the program manager with the Gloucester Centre for Community Resources home support program, and I'm also chairperson of the community coalition. Here is my colleague Carol Halstead who is the administrator of the township of Osgoode home support.

We are presenting on behalf of the Community Support Coalition of Ottawa-Carleton. We thank this committee for the opportunity to provide feedback this morning on Bill 173 and we will offer three recommendations for your consideration.

The Community Support Coalition of Ottawa-Carleton is a federation of 19 not-for-profit agencies which are directed by volunteer boards of directors. These community-based agencies evolved from the grass-roots approach in response to a need in the community and are directly accountable to consumers and volunteers. The mechanism that addressed those needs mobilized volunteers and professional resources which responded directly to the expressed needs of seniors and their families. Some agencies are also mandated to serve disabled adults. In the early 1980s, a network of community support agencies began to meet because they shared a common vision and purpose, that of enabling individuals to live independently in their own homes, with dignity. This essential network of alliances is today's Community Support Coalition of Ottawa-Carleton.

Local community action created community support programs across Ottawa-Carleton. Some are independent agencies providing solely community support services; others provide the same or similar services through separate departments of community health or resource centres, elderly persons centres or community information centres. Some are located in the rural parts of the region; others serve urban and suburban areas. The community base, consumer focus and volunteer direction are common themes for coalition members. Diversity is our strength.

A full complement of community support services is available to Ottawa-Carleton consumers. They range, for example, from transportation to meal services to respite in the home. Essentially, community support providers have become an extension of existing family systems for both consumers and care givers. For many of those we serve, we have replaced the extended family of the past.

While broader planning issues are being addressed by others, we have chosen to focus our response to Bill 173

on those aspects which impact most directly on our clients, our volunteers and the services which we provide. We will therefore offer three recommendations for your consideration. Carol will go on to talk about the recommendations.

**Ms Carol Halstead:** Recommendation 1: The community support coalition recommends that the universal requirement for a plan of service in subsection 20(1) be replaced with a graduated system for intake, assessment and service. Bill 173, as currently written, requires a service plan for each client in subsection 20(1). This, for example, could create a requirement that an assessment and service plan be done for someone who wants only to attend diners' club. Within the continuum concept, no such effort or cost would be required. However, should a client's needs progress to Meals on Wheels, an intake assessment and service plan appropriate to dietary needs would then be required. This would become more comprehensive as the client's needs increased. We strongly recommend an assessment process that is appropriate to each situation.

Community support consumers directly access our agencies, without a medical referral, when they express a need for a social service. We believe that this social services approach promotes consumer choice and independence. Service delivery, frequently provided by senior volunteers, promotes the wellness model in both consumer and volunteer. Its strength has been its flexibility and responsiveness to consumer needs. The emphasis on choice has provided the least intrusive, most cost-effective service possible, and coalition members believe that this approach to community support services must be retained.

A graduated system would parallel the continuum of care and allow the consumer to be assessed only as needed for services required.

**Recommendation 2:** The Community Support Coalition of Ottawa-Carleton recommends that a commitment to appropriate recruitment, orientation, training, supervision and support of volunteers be made explicit in Bill 173 and that further efforts be made to safeguard volunteer participation by limiting the extent to which volunteer-delivered services are regulated.

Volunteerism is the essential component of all community support services. Volunteers provide the direct link between the community and the agency, the capacity for fund-raising and the majority of direct service.

A volunteer who provides one service may be a consumer for another service. A volunteer driver from a rural area, for example, may transport consumers locally but request a drive to downtown Ottawa for his or her own appointment. This volunteer delivers one service while receiving another. As volunteers become more familiar with our organization, they become aware of the necessity to fund-raise locally. Some individuals become a service provider, a consumer and a fund-raiser. This is an affiliation triangle that may disappear if any of the affiliation is disturbed. As a result, any loss of volunteer support can significantly reduce our organizational effectiveness, our service delivery and our financial base. Since 20% to 50% of our revenues must be raised locally,

our volunteer base must be not only supported but actively nurtured. Our future depends on it.

#### 1030

Many volunteers who provide direct service do so in our sector precisely because of the personal approach taken: the opportunity to help people rather than clients. They identify strongly with their agency and with the act of volunteering, and are deterred by the emphasis on control and red tape. While a paid employee may need to tolerate perceived bureaucracy, a volunteer does not and will leave the organization. Volunteers' motivation is thus very different from that of paid human resources.

It has been our experience that those who volunteer have a clear personal connection with the agency where they volunteer. It is our belief that our system would be severely damaged, perhaps irreparably, if the volunteer connection is broken. Large parts of Bill 173 regulate direct service to such an extent that we fear a chilling effect on our volunteers' participation and, ultimately, on their participation in fund-raising and governance as well.

**Recommendation 3:** The Community Support Coalition of Ottawa-Carleton recommends the removal of the 20% limit of service by the multiservice agency in subsection 13(2). Community support services in Ottawa-Carleton are well developed. Coalition members pioneered some of our community support services in Ottawa-Carleton nearly 40 years ago, and our network has expanded so that all of the region is now served.

Agencies were created in response to expressed community needs. A great deal of effort has been expended in planning and coordination by the Council on Aging of Ottawa-Carleton, and between the agencies themselves, to ensure lack of duplication as they emerged. Clear geographic and service boundaries have been established; services are provided in French or English where appropriate and some partnerships between service providers and multicultural groups have already been developed.

There exists currently in Ottawa-Carleton a well-coordinated network of services that puts customer service first. We are the foundation of the future long-term care system in Ottawa-Carleton and we urge the government to build on that foundation.

However, it is clear that the implementation of subsection 13(2) would require existing agencies to be absorbed into a larger body and cause severe disruption in service provision. Simplified access, coordination and service delivery can be achieved without this measure. It is unnecessary in an area as well-developed as Ottawa-Carleton.

In summary, our coalition remains concerned about the overall impact of Bill 173 on the community support sector and urges closer examination of the issues. Differences between the sectors being integrated have so far only partially been taken into account by the legislation.

We remain concerned about the effect of Bill 173 on our clients. We therefore recommend that the universal requirement for a plan of service in subsection 20(1) be replaced with a graduated system for intake, assessment and service.

We remain concerned about the effect of Bill 173 on

our volunteers. We therefore recommend that a commitment to appropriate recruitment, orientation, training, supervision and support of volunteers be made explicit in Bill 173 and that further efforts be made to safeguard volunteer participation by limiting the extent to which volunteer-delivered services are regulated.

We remain concerned about the effect of Bill 173 on the services we provide. We therefore recommend the removal of the 20% limit on the purchase of service by the multiservice agency in subsection 13(2).

**M<sup>me</sup> Rashleigh :** Comme mentionné précédemment, la Coalition du maintien à domicile d'Ottawa-Carleton est une fédération de 19 agences à but non lucratif qui sont dirigées par un conseil d'administration bénévole. Nous avons choisi trois aspects du projet de loi 173 qui auront le plus d'impact sur nos clients et bénévoles ainsi que nos services.

La Coalition recommande qu'il n'y ait pas de plan de service d'établi au début, mais bien, qu'il soit graduel, lorsque les besoins du client progressent.

La Coalition recommande qu'il y ait un engagement de fait envers l'orientation, l'entraînement, la supervision et l'appui auprès des bénévoles et qu'il y ait un engagement formel et explicite dans la Loi 173 auprès de ceux-ci afin de sauvegarder leur participation. Le bénévolat est une partie intégrale des services de soutien à domicile.

Les services de soutien à domicile d'Ottawa-Carleton sont très développés. Nos agences ont été créées d'après des besoins exprimés par la communauté, et beaucoup de planification et de coordination entre les agences ont été faites pour assurer qu'il n'y ait pas de duplication de services. L'accès simplifié, la coordination ainsi que la livraison de services peuvent être assurés sans détruire et absorber les agences qui existent déjà.

We now invite questions.

**Le Président :** Merci beaucoup pour la présentation. Mr Sterling.

**Mr Norman W. Sterling (Carleton):** I'm particularly interested in talking about the volunteer aspect, representing areas where Carol is from in the township of Osgoode, which I guess has a population now of 13,000 or 14,000 people. If the MSAs take over the delivery of approximately 80% of the services, do you think the people of Osgoode will volunteer to help out the MSA as such, as they have with the township of Osgoode care centre? There's just a whole host of volunteer services which go on in that township. Part of living in Osgoode is giving back to the community.

**Ms Halstead:** There's a very strong commitment in the township of Osgoode of neighbours helping neighbours, but as the Long-Term Care Act has come before us in the last two years, I have had direct service volunteers, some of whom are board members and others who are strictly board members, who have very clearly said to me: "We will not continue to be active in this program if it is not neighbourhood-based. If we have to call Ottawa or go into there, there is no way that we will volunteer." So for many of us in the rural areas, the concern is that the clients will lose service because there are not volunteers there to provide it. That is just a rural perspective,

but I'm sure my urban colleagues have a similar perspective.

**Ms Rashleigh:** I feel that the same thing would happen. I represent Gloucester, and certainly the volunteers have told us that they like to volunteer in their own community. They would not go to a big agency to volunteer. They certainly want to retain the local involvement.

**Mr Sterling:** I think one of the aspects which is most distasteful to me in this legislation is the assumption that a big overall organization is somehow going to deliver better. In my experience, in the areas that I represent, the smaller the organization and the more dispersed the organization is, one in the town of Osgoode, one in the town of Metcalfe or whatever it is, the more effective that organization is. This just totally counters how things operate in a good portion of the area that I represent.

1040

**Ms Halstead:** Certainly, our coalition feels that because we are so well served in Ottawa-Carleton—all areas have access to service; not all the same service, but not all communities require the same service—we feel that the current system has many merits. There are always advantages to change, but to change for the sake of change can be devastating. To change the weaker links, and there are always weaker links, we see that there are possibilities there, but we also know that the volunteers who make our services happen are the crucial link, and that link, we feel, should not be tampered with.

**Mr Sterling:** Bottom line, are we better off or worse off with MSAs?

**Mr Jim Wilson:** As in the legislation.

**Mr Sterling:** As in the legislation.

**Ms Halstead:** It's a very difficult consensus question because we represent 19 not-for-profits. Certainly, we feel if it's a very narrow focus and that we're forced into amalgamation, if the little agency disappears, we would say that is a very negative aspect, but you could have an MSA, we feel, that maintains the individual agency but has a linking network, and that we see has very real positive possibilities for the clients and the volunteers.

**The Chair:** Again, time presses on. We thank you for coming before the committee this morning.

ST PATRICK'S HOME OF OTTAWA

**The Chair:** I call upon the representatives from St Patrick's Home of Ottawa.

**Ms Maureen Goodspeed:** Good morning. My name is Maureen Goodspeed. I chair the board of directors of St Patrick's Home for the aged here in Ottawa. With me today is Lawrence Grant, our director of finance and human resources.

St Patrick's Home was founded in 1865 and is sponsored by the Grey Sisters of the Immaculate Conception. Since then, the home has responded to community needs evolving from an orphanage and an asylum for the indigent to today's fully accredited charitable, non-profit long-term care facility for the elderly. Throughout its evolution, the element of loving care has been constant at St Pat's.

We have a history and a reputation for leadership and innovation in the design and delivery of long-term care and community services to seniors. Some of our programs include:

- The first seniors' day care program in the region.
- A one-year pilot day program developed by the Alzheimer's society for their clients.
- Two specialized seniors' day programs funded through a Trillium grant for a three-year period: one for seniors with physical disabilities and one for the cognitively impaired.
- Meals on Wheels services for the surrounding community five days a week.
- Telephone assurance programs providing daily contact for homebound seniors.

Each of these programs assist seniors to remain safely and comfortably in their own homes as long as possible.

Program quality is extremely important to St Patrick's Home. In 1979, the home was the first in the region to become accredited, and we have maintained a three-year accreditation status ever since. We're proud of our stellar reputation in the community and of our leadership in the field of long-term care and of our partnership with government and other community agencies in developing a comprehensive response to the needs of seniors in Ottawa-Carleton.

We have always supported the province in its determination to reform long-term care services and we understand the government's concern with demographic projections indicating an unprecedented increase in the population of Ontario's elderly. It is important to remember, however, that more than 90% of seniors remain in their own or in their family's homes. The provision of viable services to seniors demands a share of responsibility between care providers and governments and a clear understanding of consumer needs.

We recognize the significance of Bill 173 in attempting to address these issues. On behalf of St Patrick's Home, we thank you for this opportunity to participate in the consultation process.

I would like to discuss with you our areas of greatest concern and then conclude with specific recommendations for change. We have eight recommendations.

First of all, it's important to know that we concur with the seven stated purposes of Bill 173. However, we are very concerned that the bill, as it is presently drafted, does not provide the framework within which they can be realized. I would like to review and comment on each subsection of part I of the act.

First of all, a wide range of home-based community services must be available as alternatives to institutional care. However, Bill 173 builds a wall between community-based and facility-based services rather than an integrated health and social services system. It fails to recognize the leadership and contributions that institutions provide in maintaining the independence of seniors in their own homes, and the bill also fails to recognize that facility-based care is a necessary component in a comprehensive long-term care system. This runs directly counter to the intentions of long-term care reform.

The quality of community services and the promotion of the health and wellbeing of persons requiring such services must be assured. Bill 173 provides a rigid formula for the provision of services, which does not allow sufficient flexibility to provide the creative innovation necessary to meet the increasing and changing needs of seniors. This bill does not reflect a workable vision of independent life for seniors in the community. Rather, it is concerned with control and uniformity, which precludes independent decision-making by the consumer.

It also fails to recognize the multicultural considerations required by a diverse population. Static evaluation criteria do not recognize the diversity of the population and its range of correspondingly different needs which should be addressed by quality programming. Much of the detail in this act properly belongs in regulations, where it can be modified as required through administrative means.

As it is written now, this bill sets parameters on the services the province is willing to consider and fails to provide for the development of new, better and more cost-effective ways of managing resources for the care of the elderly.

The needs and preferences of the care receiver must be recognized. Bill 173, in its present form, makes no provision for choice or decision-making on the part of the client. Their needs will be assessed, analysed and determined through the MSA, and their only options will be to accept or decline whatever service is offered. The bill tears down the existing structure of community support services without providing any meaningful replacement, as you've just heard from the previous presenters. We are not aware of any new initiatives to expand these services in the community.

We are also concerned that the absence of user fees removes an element of control and decision from the user. It also places an unsupportable financial burden upon the province. By failing to allow for the payment of user fees, Bill 173 dramatically alters the relationship between the service user and the service provider. It creates an inconsistency in long-term care whereby seniors receiving facility-based services are expected to pay a user fee and seniors receiving community-based services are not.

As well, while the intent may have been simply to ensure that no one in need would be denied service because of inability to pay, the effect is to remove an element of decision and control from all users. The present system of user fees based on a non-intrusive means test guarantees that services are available to everyone.

We are pleased to see that the need to improve access to services has been identified in Bill 173. However, the bill describes the creation of a large bureaucracy which, far from simplifying and improving the system for clients, unnecessarily complicates service delivery and threatens the destruction of programs now available to seniors. What we really need is an agency to plan, coordinate, direct and monitor services for seniors living in their own homes to ensure that their needs are most efficiently met.

We agree that the system must be simple, accessible and fair. The level of detail in the proposed legislation is excessive, to the point of jeopardizing the effectiveness of the MSA. Bill 173, as it now reads, calls for the dismantling of a system of long-term care that has evolved over many years, a system that is built on diversity and recognizes the unique aspects of care which are essential to the individual.

The key to a successful new system is not a simple approach to meeting complex needs, but a system that meets complex needs through clear and easy access and assessment, assessment done in a way that reflects the dignity of the clients served. Assessment must include consideration for all human needs, including physical, spiritual, psychological and social needs. Care, and especially in-home services, must recognize the vulnerability of the clients served and be supportive, comprehensive and efficient. Delivery should be provided by as few individuals as possible.

#### 1050

The efficient management of human, financial and other resources involved in the delivery of community services is vital to the reform of long-term care. Bill 173 seems to equate efficient management of human resources and financial management with direct control. Instead, there needs to be a delegation of responsibilities whereby the MSA is restricted to management activity.

It should be noted that the costs of the present system are greatly reduced as a result of the contributions of volunteers, both as direct care providers and as charitable fund-raisers. Volunteers identify strongly with the institutions and agencies they support because they recognize the mission and values of the institution as an extension of themselves.

A ubiquitous government agency will not generate a similar passionate commitment, and the province cannot afford to replace the services provided by volunteers with paid labour. Both the quality and the quantity of care provided will deteriorate. It is contrary to good management and accounting practices to have the funding agency and the care provider be the same, but that is exactly what Bill 173 demands of the MSA.

There is a need to encourage local community involvement in planning, coordinating, integrating, managing and delivering community services, and we presently enjoy such local community involvement through the work of volunteer boards of directors of charitable institutions like St Patrick's Home, through the work of care-giving volunteers and through our fund-raisers. However, Bill 173 will remove the "community" from community services through the establishment of an MSA which is expected to be all things to all people. Bill 173 will result in the eclipse of volunteer-based community programs, will drastically alter the nature of governance and destroy our heritage of long-term care.

We have already commented that it is inappropriate for an MSA to be both funder and care provider. It is also unrealistic to project that in four years MSAs would be in a position to purchase only 20% of services from other agencies. This suggests a general erosion of services which are now available. No clear plan has been pro-

posed whereby services presently available will be replaced.

An eighth purpose should be added to include support for families and informal care givers. The bill as it is written now fails to recognize that 90% of seniors live outside of institutions without structured programming, and this underlines the substantial contribution of family and other informal care givers.

Very briefly, this is an outline of our major concerns. We hope that the following recommendations will assist you in redrafting the bill.

(1) We recommend that distinct agencies be responsible for the purchase of service and the provision of service. The role of the MSA should be based upon a brokerage model whereby the MSA determines the need and tenders for services, assuring the best value for money.

(2) We recommend that legislation include recognition and support for family and other informal care providers, who are the primary providers of care to seniors.

(3) We recommend that the MSA budget include an allocation for pilot or demonstration projects, with the intention of developing new, innovative and cost-effective programs to meet the changing needs of an increasingly elderly population and their informal care providers.

(4) We recommend that program design and care needs assessment specifications recognize the cultural diversity of the population.

(5) We recommend that the contribution of charitable organizations and volunteers be recognized and fully incorporated into the revised long-term care system.

(6) We recommend that the new system include provision for user fees.

(7) We recommend that the phase-in period reflect the actual time required for planning and development to accomplish the objectives of the reform and that the proposed four-year implementation period be considered a guideline only.

(8) We recommend that all items dealing with control or accountability procedures be removed from legislation and placed in regulations to provide the flexibility required in the development of a comprehensive and effective long-term care system.

To be successful, the redirection of long-term care must build on and enhance the strengths of our present system, it must be sufficiently flexible to meet new challenges and it must be cost-effective. If this is to be accomplished, the experience and expertise of the present care providers must be considered a valuable resource.

As it is presently written, Bill 173 is not adequate for its purposes and is a threat to many of the organizations providing care and services to seniors. At a time when care providers and government should be working together, this bill will create an adversarial situation.

This consultation process is an important step in bringing government and care providers together, but it can be successful only if input from the front-line workers in long-term care is taken seriously. It is important to realize that the group most impacted by this

legislation, the elderly and the chronically ill, are not in a strong position to make their opinions heard.

Nothing I have said today is intended to delay change. But I am very concerned that when change occurs, it be for the better, to make the long-term care system in Ontario more readily accessible and more effective for all. Bill 173 needs extensive revision to achieve this goal. I hope our recommendations and those of other care providers and our clients will assist the government in preparing appropriate legislation.

Thank you for this opportunity to explain our concerns and expectations.

**Mr Gary Malkowski (York East):** Thank you for your presentation. Do you have a formal mechanism in your provision of service?

**Ms Goodspeed:** I'm sorry?

**Mr Malkowski:** Do you have any formal mechanism for consumers to provide feedback regarding the service provided?

**Ms Goodspeed:** We've done a number of surveys and we are in constant touch with our own clients and the families of the people we work most directly with.

**Mrs O'Neill:** Do you have a residents' council, for instance?

**Ms Goodspeed:** Yes, we do.

**Mr Dalton McGuinty (Ottawa South):** Maureen, it's good to see you again to help acquaint some of the committee members with the history of St Patrick's Home. At a time when it's become fashionable almost to criticize some of the charitable organizations that are religiously based throughout the country, I think it's important to remember that a lot of the services, like schools, hospitals, universities and orphanages, were all originally run by religiously based institutions.

One of the constant criticisms we hear with respect to this bill is related to the negative effect it's going to have on the volunteer spirit that's extant in our communities, and I wanted to raise a particular issue here which I don't believe has been raised. We have all kinds of volunteer boards of directors, obviously, administering these kinds of services which form the subject matter of this bill. I want to get your feedback.

The bill provides that the minister will be appointing directors and program supervisors and then he or she will also be affording those directors and program supervisors immunity from liability. We won't be able to sue them. These will be people in paid positions who we will not be able to sue as long as they're acting in good faith. What about our directors who are sitting on volunteer boards of directors? Can they not now be sued?

**Ms Goodspeed:** Oh yes, they could be sued.

**Mr McGuinty:** What do you think of this immunity from liability we're giving to government appointees?

**Ms Goodspeed:** I think it's a very backward step. I think the directors of an institution ought to be able to be held accountable for the decisions they make and for the policies they implement, and I think to make a publicly appointed director invulnerable in a situation is a very retrograde movement.

I think a publicly appointed director is not going to have the same understanding of the mission and values of the institutions that we have now. I don't think they're going to be able to bring the same kind of intensity to their work. They're going to be spread too thin and they're not going to be able to identify as closely with the institutions they are responsible for as the people we have doing the work now. I think we stand to lose the largest and best part of our heritage in this way.

**1100**

**The Chair:** Does the parliamentary assistant want to make a comment?

**Mr Wessinger:** Yes. Just to clarify, what is referred to about directors in the act are those who work for the ministry, for the government, not anything relating to any agency. Second, I'd like to make it clear that there is liability on the crown for any act of a program supervisor, so there's a clear liability of the crown for any acts of a program director. It only excuses the individual; it doesn't excuse the government from liability for their wrongful or negligent acts.

**The Chair:** I thank you both for coming before the committee this morning.

#### BRADSON HOME HEALTH CARE

**The Chair:** I call on the representatives from Bradson Home Health Care.

**Ms Allayne Evans:** Good morning. We want to thank the committee for allowing us the opportunity to speak with you about the role of the private sector in Ottawa-Carleton. My name is Allayne Evans and I spoke to you once before in Toronto as a vice-president of the Ontario Home Health Care Providers' Association. I'm here to speak to you today from a more personal perspective as a vice-president of Bradson Mercantile Inc, which is a private, commercial company.

With me are Tristan Mostovac, from our Ottawa office, and Margaret Simons, from our Kanata office, two front-line workers. They've been recommended by their supervisors to come before you to answer any questions you may have about employment in the private sector.

First, I'd like to give you a brief word about Bradson. We're a wholly Canadian-owned company established in 1957 in Ottawa. We've been doing temporary staffing for 37 years. We're one of the largest privately owned suppliers of contract, temporary, technical, professional, health care and securities staff in Canada.

In 1986, after market research and analysis of the health care field, Bradson Home Health Care was created. By May 1986, we were properly insured. We had policies and procedures in place and field staff were identified, referenced and trained.

The first office opened in downtown Ottawa. We began by providing registered and certified staff to acute, chronic and nursing home institutions in the region. In April 1987, we won our first contract with the regional municipality of Ottawa-Carleton. That contract has been renewed in 1990 and 1993.

One of our objectives has been to maintain and keep the client independent in his/her own home. In 1989 we launched three Bradson seniors' programs in Nepean. The

focus of each has been to provide an environment within the community where seniors could meet, socialize and provide support to each other. In 1988 we opened a satellite office in Gloucester, which is east of Ottawa, and in 1990 we opened one in Kanata, west of Ottawa, to better serve both our public and private clients in the eastern and western parts of the region. December 1991 saw the opening of another health care office, in Kemptville, to the south.

We have used our profits to expand, to grow, to be closer to both our client base and our employee base. Since 1986, we've invested in home care by opening offices and providing employment for local people. People are more comfortable, we've found, in dealing with an office that's in their neighbourhood, whether it's applying for work or whether it's requesting service. Whatever communities we work in, we contribute. It's our policy to purchase other services from that community such as advertising and equipment rental. We pay rent, we take out leases, and we pay business taxes.

We volunteer in many community agencies. My staff or I sit on a committee for the council on aging. We are members of the Registered Nurses' Association of Ontario. We're members of the Gerontological Nursing Association, the Ottawa-Carleton Industrial Training Council, the MSA working group at the district health council. We are charter members of the Canadian Home Care Association and Home Support Canada, and we also support the Ottawa-Carleton Palliative Care Association. We are as dedicated and committed to what we do as any other agency, no matter what our incorporation status.

We discovered in 1989 that the demand for trained workers far exceeded our ability to get the training at the local community college, so we set up a private vocational school, level 2, home support worker course, which is recognized by the Ministry of Education and Training. We train at our own expense at our local private vocational school.

One of the standards in this area of the province is that when we're under contract to the region, we must have 85% of our home support workers trained to level 2. The Ottawa-Carleton home care program established the standards, and all our agencies that are on contract have been audited against those standards annually for the last two years.

We've also been working for two years on developing our own customized software. All of Bradson Home Health Care staffing, billing, time card management, scheduling and criteria-matching are done on the computer. This allows us to have a high rate of efficiency with our home support workers' schedule and a low margin of error.

We provide essential services to the community and we work long hours to be cost-effective. The provincial government regulates the profits in our industry by setting the pay rate for employees and the billing rate we are allowed to charge. Any profit that is made is based on good business practices and full accountability. Governments don't bail out small business. We either make a cost recovery or we go bankrupt.

I'd like it noted that when it came to the social con-

tract, it was decided that we were responsible enough to be considered as one of the agencies that should be brought in, and we have been told that we will be contributing for the next three years. At the time we were suffering under the not-for-profit policy of 90-10, we were also being forced to meet financial targets set by the government—and we've done that.

The private sector can deliver the same or higher standards of care for the same amount of money or less than the MSA and at the same time we can provide choice. Why should the government insist on limiting us to 20%? Removing the private sector as a partner in the delivery of home care removes flexibility, competition and the ability to respond quickly to the changing needs in the community. I'm worried that if you reduce our involvement too much in the publicly administered system, not only will you cause serious job loss and dislocation to both clients and employees but you may, in the long run, hasten the advent of a second tier of unregulated health care delivery.

It's been a common experience to all of us that when government tries to create a mouse, it becomes an elephant.

We believe we need to step back and examine what values should be driving the change in the system. When we do that, we see that the overriding value is the need to deliver more quality care in the home by better meeting consumers' needs.

Marg Simons has asked to speak to you.

**Ms Margaret Simons:** Good morning. My name is Margaret Simons and I work for Bradson Home Health Care as a home support worker. I'm not used to public speaking, so I hope you will please bear with me.

There are a number of reasons that I choose to work for Bradson's. It is a well-established, solid Canadian company. It treats its employees fairly and with respect and consideration. Bradson's provides training at no cost to the employee. I took my level 2 course through Bradson's and all it cost was my time. It was offered at night also so that I could work during the day, which was important to me, and it was an excellent course.

Bradson's also offers to its employees free monthly in-service nights that cover such topics as depression in the elderly, behaviours associated with Alzheimer disease, understanding the needs of the chronically ill and the needs of their families; basically, up-to-date material that helps us as home support workers to understand our clients better and shows us ways to implement that knowledge more effectively on a day-to-day basis. This in-service also gives us a chance to interact with our peers and our supervisors.

Bradson's is a tight-knit company, and as an added incentive to attend the in-service, Bradson offers a complimentary dinner to anyone who attends. Most of the time it's just soup and buns and cheese and meat, but it's just their way of encouraging us to learn more. These nights are invaluable. They keep us up to date and focused on what we need to accomplish.

1110

What I'm really getting at here is that even though

Bradson's is a fee-for-service agency or, if you like, a profit agency, it does not cut back on its expenditures in regard to its employees. We are paid the same rates as other agencies, be they profit or non-profit, and all the agencies receive the same moneys from government funds.

The quality of care for the client is in no way compromised. We as home support workers are periodically evaluated. We are encouraged to maintain high standards of conduct, treat all our clients with respect and dignity, maintain client confidentiality and to perform our tasks as quickly and effectively as possible.

We are required to put in monthly reports on each client, noting any changes in their condition. Any problem we might have is reported directly to our coordinator. If for any reason she can't speak to us immediately, she gets back to us as soon as possible, and it's usually within a few minutes.

Bradson runs a tight ship, its priority the best possible care for the client.

We all know that demands for home care are increasing rapidly. People are living longer, hospitals and nursing homes are overcrowded and the costs are enormous. We all know this. My concern, or one of my concerns, is that the people who need the services the most will be the real losers if Bill 173 is passed. Although I am sure that the present system could be improved upon, I don't think what this bill proposes is the answer. This bill would eliminate any competition from other agencies. The government would have a monopoly on these services. I think this would result in inferior service, impersonal care and ultimately a reduction in service.

As a home support worker, I see at first hand the needs of my clients. For many seniors, we are the only person they see on a continuous basis. They get very upset if someone else has to replace their regular worker. They have suffered many losses, and they're vulnerable, afraid and often very lonely. They need well-trained home support workers they can depend on and trust. This bill cannot be passed without more study. These people who are being helped today are you and I of tomorrow.

I am a good home support worker. I show up for work every day, and by that I mean I work to the best of my ability. I work hard with my clients' best interests at heart. My client, from the time I arrive until the time I leave, gets everything I have to give. I clean, make dinner, wash clothes, bathe, toilet, and transfer them. I am conscious of any sore, bruising, swellings or any abnormalities that may be a symptom of something more serious. I am a valuable member of the home health care team, and I will, in all probability, under this bill lose my job.

I am concerned, and rightly so, that Bill 173 will cause the closure of Bradson Home Health Care and other fee-for-service agencies. These are healthy companies that are competing well with non-profit agencies. They are doing a good, efficient job. They are providing competition and employing a lot of people.

**Ms Evans:** We're open for any questions.

**Mr Sterling:** I have a question of the parliamentary assistant. I understand the private sector is now providing just under 50% of home care in the province. If they are providing it at a lesser cost than the non-profit organizations and are paying additional taxes so there's some come-back for the provincial government, why do we want to—not "we"—why do you want to put them out of business? If we can get a better deal, that the employees are getting paid just as much as the non-profit organization, they're getting less per hour than the non-profit so there's a smaller payout from the provincial government, and they're paying additional taxes back, why on earth would you want to put them out of business?

**Mr Wessinger:** I think we have to look at the aspect of the question of the service delivery concept. The concept of the MSA is to move to an integrated service delivery concept. It's not related, really, to the question of—I think it's the fragmentation of existing services that really is the difficulty.

If I might just indicate, for instance, just a week ago I had an example in my own constituency about a problem with fragmentation of services, where there was a change in the medical condition of the patient who was receiving home care. The information was clearly communicated to the VON who was delivering the nursing services. There were two different homemaker services involved in providing homemakers to the individual, one profit and one non-profit, and there was no communication of a change in medical condition to the homemakers. When you have such a fragmented service delivery, I think you have many communication problems arising. It's a question of preference for a clearly integrated service model.

**Mr Sterling:** But I'm talking about the 80-20 split. That other stuff has nothing to do with the question I'm asking.

**Mr Wessinger:** Yes it has, because the 20% applies to non-profits just as much as it does to for-profit. There's no distinction in the question of purchased service. It's not related. It affects the non-profit agency just as much as the for-profit.

**Mr Jim Wilson:** Just a point of clarification, though: In the parliamentary assistant's response, he's somehow dragging the private sector into his response about this local example he had of this problem with coordinating service. Mr Wessinger, you have 96% delivery of services in your riding by the not-for-profit sector, so I assume your example more than likely is an example coming out of the current system that's in your riding. It has nothing to do with the question asked by Mr Sterling.

**Mr Wessinger:** I was answering the question and indicating that really the policy had to do with an integrated service delivery model. There's no question that if your concept of a service delivery is a consumer service, a purchased service, a competitive service for delivery in the community, then of course there would be the validity of the thing of, why should one be concerned about the aspect?

But if you're looking for an integrated service model, like we do in the health care system in the institutional

side—it is an integrated service delivery, the hospital model.

**The Chair:** For our witnesses, would you like to make a comment on that before we have to finish this session?

**Ms Evans:** Obviously, we agree with Mr Sterling: Why the 80-20? That was really the purpose of our being here. We just don't understand the purpose of section 13. We came before the committee to show you that we are responsible employers, that we are doing a good job. Quality of care is not an issue. We can save you a lot of money by providing this service in administration costs, so please leave us alone and get rid of the 80-20.

**The Chair:** Thank you very much for coming before the committee this morning.

MARIANHILL

**The Chair:** I call on the representatives from Marianhill. Welcome to the committee.

**Ms Isabel Leach:** Good morning. My name is Isabel Leach, coordinator of the Dr L.U. McCluskey Centre at Marianhill. The centre is part of the Marianhill community Alzheimer system, the goal of which is to enhance the interdependence of care givers and persons with Alzheimer disease or a related dementia. The conceptual framework is enclosed in the folders you received. With me today is Eileen Sicoli, coordinator of pastoral care at Marianhill.

It is certainly a privilege to live and work in an open and bureaucratic system where opinions are sought on such critical social policy issues as Bill 173. We trust that our concerns will be taken into consideration before the next reading of the bill. Just to let you know, our presentation is outlined in yours.

Marianhill, a private, charitable home for the aged, is not only an excellent long-term care facility but it offers the elderly of our community with a continuum of care. Dr Jennifer Ingram, a noted geriatrician, in an article in Thomson newspapers said, "Anyone considering a career in gerontology should visit Marianhill." In a cost-effective and efficient manner, Marianhill has developed numerous programs integrating those in the community with the facility.

Because of the lack of specialized programs for persons with dementias, the Marianhill community Alzheimer system was developed. Our experience in the community demonstrated a need for this latest innovation. The unique Dr L.U. McCluskey Centre offers an extensive assessment process for victims, with family-focused support for the care giver. Our experience and the knowledge of other care systems that we have been sensitive to demonstrates that the proposed legislation has shortcomings.

1120

Specifically, we are concerned about: the limited attention paid to special populations such as those with Alzheimer disease; the insufficient attention paid to the history of innovation in the private sector; the anticipated escalation in costs; the bill not being sufficiently family-focused; the need to address preventive measures such as specialized housing; and the failure to recognize the role

of the health care facility in the long-term care spectrum.

In the full text of this document we deal with all six issues, but today, for the sake of brevity, we will speak to only three. Our oral presentation is outlined in the full document for you to follow.

In Canada, 5% to 10% of people over the age of 65 and 20% of those over 80 suffer from Alzheimer disease, and reports are that this figure is probably underestimated; it also does not include the related dementias which can cause similar problems for care givers. This is, and will be in the future, a significant number of people who will require assistance from a long-term care system.

Numerous attempts have been made to identify those programs and services which impact upon the life and health of people with a dementia and how they must be integrated functionally. Although extensive work has been undertaken to evolve models to service the frail elderly, for the most part they are experimental and a consensus as to the organization of the community service system has yet to emerge. Primarily, the focus has been to the physically disabled, not to the person with a dementia and their care giver. For example, many homemakers are not skilled in dealing with the special problems occurring from a dementia. Bill 173 must more adequately address this area.

In the June 1994 Gerontologist, Joshua Weiner states that by the end of this decade virtually all the parents of the baby-boom generation will be elderly; many of them will be very old and starting to use long-term care. These elderly will turn to their children for care. No longer will this be a purely academic issue; long-term care will become an intensely personal issue. The elderly of tomorrow will be better educated, have varied social and economic backgrounds, will be more technologically advanced and will have been more mobile. For many people it is tolerable for a disabled mother to live with her daughter and to spend most of her time at home. This may become less evident over time as the baby-boomers age and demand more independence. We will expect more of the system that we have helped finance for years and we will expect more say in the services we require.

We worry that this legislation is not really looking to the future; rather, it is looking only to correct past mistakes and cut costs.

Related to the demographic developments are changes in family structure—reduced child-bearing and longer life expectancies—resulting in more generations within families but fewer children in the nuclear families. These demographic developments, in particular cohort succession and kin availability, may constrain future developments in family forms and functions. These statistical characteristics present social policy strategists with challenges in shaping political and bureaucratic structures that can buttress family support. If ever there was a time for a new paradigm to guide long-term care policymaking, it is now.

Large monopolies, especially government bureaucracies, are not known for their innovative ideas. Healthy competition among a variety of agencies stimulates creativity in an effort to reach excellence. Marianhill is an excellent example. Marianhill is known across the

province and in many parts of Canada for its varied innovations in community and institutional care. Bill 173 will stifle this kind of creativity.

Eileen will now focus on the family-focused assessments.

**Ms Eileen Sicoli:** Since relationships can be drawn between an elder's quality of life and a supportive family network, more attention to empower this network must become the focus of formal policy and practice initiatives. Instead of saying we will "do for you," why not say we will "assist you to do"?

Bill 173 and its resulting large bureaucratic MSAs raise two issues in this respect. The first is of control of the individual home help. If this worker is in the community to support and assist the individual client or care giver, it might be suggested that the client should have control over that worker. However, the fact that the organization can withdraw and substitute workers demonstrates that the care giver does not have control over the worker; secondly, nor does the care giver have much hope of successfully protesting at such changes. Should the person attempt to resist change and want to maintain contact with a known, liked and trusted worker or complain in any way to maintain control over his or her lifestyle, he or she is most likely to be labelled "difficult" by the organization or it will be noted as a further expression of the person's problems.

Why not empower care givers? Train them to be their own case managers. Think of the cost savings in personnel alone. Long-term care reform, as it was originally planned, with one-stop access to information and referral, would have been a good start to empowering care givers, allowing them the choice, knowing that they and not the government know best what their needs are. We believe this government has not paid sufficient attention to empowering care givers and is in fact taking most of that right away.

Studies confirm that care givers in Ontario are confronted with an arduous responsibility. Care givers are at an advanced age and often in frail physical condition. They suffer from numerous symptoms associated with the burden of care giving.

A review of informal care giving literature reports a number of critical findings that are essential to practitioners to alleviate care giver burden. I wish to mention three of them and their relevance to Bill 173.

First, the finding that care giver burden is not solely influenced by a person's level of impairment means that service providers and clinicians must look beyond the objective functional status of the person in order to adequately support care givers and enhance their effectiveness.

Second, because care givers differ dramatically in the kinds and levels of burden they experience, no single service program or even a limited set of programs will be adequate to restore the wellbeing or enhance the effectiveness of all care givers.

And third, efforts to alleviate burden by providing social support must recognize the importance of the value and meaning that the care giver attaches to this support.

Simply providing additional units of support is not valued if the care giver views the meaning of support in terms other than that of providing understanding and respite.

With Bill 173, if one's needs are not met within the basket of services, will there be alternatives? How will they be determined? In working with care givers of persons with Alzheimer disease, one of the main problems in the community is that of wandering. Nowhere in the basket of services is there sufficient help for the care giver who 24 hours a day, seven days a week, must keep their eye on their loved one. The care giver is able to do all her household chores, assistance is not needed in personal support, and transportation is not an issue. Two nights a week respite might help a little, but what about the other five nights and seven days? Adult day care might help, providing the facility is able to cope with wanderers, and night care might be even better. However, there is little in this legislation that will be of any real assistance.

In Partnerships in Long-Term Care: A New Way to Plan, Manage and Deliver Services and Community Support, "Decisions on services offered will be based on need as measured by standard assessment methods." This sounds like more checkmarks. Will the above person be eligible for any service because he or she doesn't meet the criteria? If this person decides that her loved one would be better cared for and safer in a specialized Alzheimer unit, will that be an option? Are there special units available in her area, or will she be told that she doesn't qualify because she doesn't meet the criteria?

Will the care giver have access to people who are knowledgeable and skilled in a particular field, or will everyone be treated generically? Will the increased availability of home and community services deny people access to institutions if, according to the assessment, they could be looked after at home cheaper than in an institution?

If there is a waiting list for community services, how will priority be established? Will someone with medical needs take priority? Will this care giver, who is not only extremely stressed but totally exhausted, be told that she has to wait? Will the MSA provide education to the family member so they can understand the progression of the disease and not become a second victim?

The rudimentary menu of services for care givers frequently results in an overusing or misuse of service that is available. Inappropriate servicing may influence care giver burden and frustration.

1130

**Ms Leach:** We believe Bill 173 will take away our freedom to meet the needs of our community as we see fit. Marianhill is progressive and I believe we are a forerunner, an example of what can be done for people in our community. We object to the introduction of MSAs as being the provider because we feel they will take away our identity and our individual initiative to provide programs.

Our values date back to our Catholic heritage in the late 1700s, but we provide professional and compassionate care to Catholics and non-Catholics alike. We do not

want our mission to change from continuing Christ's healing ministry through a wide range of services to continuing the government's ministry through government-run services. It changes our philosophy, and this is not acceptable.

The Marianhill community alzheimer system, a unique, innovative program, is a prime example of empowering care givers. It is a community-directed program based in an institution, so it uses the best of two worlds. With specially trained staff, we're able to offer care givers of persons with Alzheimer disease or a related dementia an array of services, and at the same time we support the care givers in choosing service appropriate to their needs. We work closely with other community agencies by developing ways to ease communication and transfer information. If one of our services does not meet the needs of the care giver, we refer them to those that can.

What care givers like best about our system is that they gain knowledge of the disease and its process. They learn techniques to cope better with problems encountered. They know that 24 hours a day, seven days a week, they can access someone who is knowledgeable in the field and that there is somewhere they can turn in crisis.

We do not know how our system will be affected by Bill 173, but it will be unfortunate if this system, which is hailed by experts in the field as being one of the most innovative efforts to help people with Alzheimer disease, is dismantled.

**Ms Sicoli:** In conclusion, let me summarize our concerns.

Is this legislation truly a vision for the future? Does it take into consideration the changing demographics and future needs of the elderly population?

Will it stifle innovation and community initiatives?

Will MSAs truly be able to offer quality community care in an efficient, cost-effective manner?

Should we not be looking to empower care givers rather than taking away their right of choice and control?

What is the assessment process, and will it determine the real needs of the person and their care giver in a cost-effective manner? How will priority of service be determined?

Are the specialized housing needs of persons with a dementia to be part of the mandate of this legislation?

Where do long-term care facilities fit into the system? Will they become even less of an alternative for those seeking help?

Finally, we do support MSAs as being a coordinating body. We object to the exclusion of any reference to the needs of persons with Alzheimer disease and related dementias. We recommend you include legislation to deal with the three key areas we have expanded on today. Thank you.

**Ms Gigantes:** First of all, my understanding of Bill 173, and you can tell me how you see it differently, is about the use of public funds for the provision of health care services for people who have chronic health and support needs. So we're not talking here about how people choose to spend their own private moneys; we're

talking about where the taxpayers' money is spent in support of the health of people with those chronic needs.

Could I ask how people pay for services at Marianhill and how that relates to what we're discussing in Bill 173? Do you do a purchase of service with some arrangement, or do people pay their own fees independently?

**Ms Leach:** I think it depends. All the services that we talk about, we provide, and it depends on what service it is what payment is required, if any.

**Ms Gigantes:** Could you give us a bit more detail?

**Ms Leach:** Do you mean specific examples?

**Ms Gigantes:** Yes, about the categories of service and how people receive them and how payment is made for those services from your base at Marianhill.

**Ms Leach:** For instance, adult day care?

**Ms Gigantes:** Yes.

**Ms Leach:** I shouldn't really talk about this too much because I'm not an expert in this, but I believe they pay for their meals and the rest is provided by Marianhill.

**Ms Sicoli:** I know our latest program that we have added is the palliative care, but that is under our chronic care beds, so they do not have to pay for that; that is totally provided. And as well the residents who come into Marianhill pay as anyone else who would go to a not-for-profit home. They pay a flat fee and then all of the programs are available to them as well.

**Ms Gigantes:** I'm trying to understand how it is you see services being affected by what is contemplated in Bill 173, which to my mind is at its essence a method of making sure that people's needs are being met in some system that provides priority based on assessment and need.

**Ms Leach:** I think we agree that everybody should be provided with services, but there are a lot of people out there doing a good job of that. According to what I see in Bill 173, it looks like the government is trying to be all things to all people, and I'm not sure that's possible. I agree with Bill 173 being a coordinating information referral so that people are aware of and can access the various agencies and various services out there. We're concerned with the provision part.

**Ms Gigantes:** In essence, if I could put it to you, we had an earlier submission from a group that said government should not be providing funding and providing service, but that's what every hospital does, and an MSA is going to be an independent, non-profit agency made up of people drawn from the community it serves. I don't understand this fear and loathing that seems to exist about an MSA.

**Ms Sicoli:** I think the fear comes from the point that we fear some of our services will be taken away and will be put under the MSA. Being a non-profit institution, we come from our own mission, our own philosophy, and these services will not be delivered in the same manner as they are being delivered right now. They will be delivered according to a government-run philosophy as such, and that personal touch that we have worked many years to be able to deliver and that our people are quite happy with could be lost.

**Ms Gigantes:** You have a board, though, and an MSA will have a board drawn up—

**Ms Sicoli:** We have a volunteer board.

**Ms Gigantes:** Yes, and the MSA board will be a volunteer board drawn from members of the community.

**Ms Sicoli:** It is my understanding, and correct me if I'm wrong, that the board will be appointed by the government.

**Ms Gigantes:** No, you're wrong.

**Mr O'Connor:** Mr McGuinty raised that as a point this morning, but it was actually wrong.

**Interjection:** Elected.

**The Chair:** I'm sorry, I'm going to have to intervene because I'm afraid we're getting—

*Interjections.*

**The Chair:** Excuse me. I regret that we're at the end of our time and we'll have to move along.

**Mrs O'Neill:** Mr Chairman, could we have the clarification that we got in writing this morning from Mr Quirt? I don't think it's fair to leave this answer the way it's sitting.

**The Chair:** The clarification of?

**Mrs O'Neill:** Of the board, the governance of the MSA.

**The Chair:** Parliamentary assistant.

**Mr Wessenger:** I'm not certain what the request is, but perhaps Mr Quirt can respond.

**Mrs O'Neill:** How the board is elected I think is important.

1140

**Mr Geoff Quirt:** Some of the presenters have interpreted a section of the bill that talks about the minister appointing directors. That section of the bill talks about the powers that the minister delegates to civil servants like myself and about 17 other people in the long-term care division. It's government ministry functions where the minister says, "I empower this civil servant who works for me to carry out that particular function on my behalf."

The government has no intention to appoint the members of the board of directors of the multiservice agency. The government's policy is that the multiservice agency be a not-for-profit corporation and, from a policy perspective, it urges that at least one third of the members of the board of the multiservice agency be people consuming services that are delivered by the multiservice agency.

**The Chair:** I'll give you a chance to make the last comment on this.

**Ms Leach:** I was just wondering if the government has any say in the appointment of these people.

**Mr Quirt:** No. The government would receive a proposal from the district health council that would talk about the area that the multiservice agency would serve and would talk about how that board of directors would be developed. We expect they'll be elected in most cases from the membership, in the same way that your board of directors is probably elected in your not-for-profit charitable corporation from a membership.

**Ms Sicoli:** Our board of directors is not elected.

**Mr Quirt:** The government will not be saying, "This is the person we want on the board of the multiservice agency." The government will be establishing policy to ensure that consumers are represented, and they've also asked that representation make sure that social and health perspectives are represented. But that's the policy framework within which communities will decide themselves who are going to be members of the board of directors of the multiservice agency.

**The Chair:** I'm sorry; we are going to have to move on. I'm sure that as we deliberate in clause-by-clause we'll try to settle that one more clearly.

#### SERVICE D'ENTRAIDE COMMUNAUTAIRE POUR LES AÎNÉES ET LES AÎNÉS FRANCOPHONES

**Le Président :** Maintenant, j'invite les représentants du Service d'entraide communautaire pour les aînées et les aînés francophones. Merci d'être venus ce matin. Nous avons reçu deux documents. Si d'abord vous pouvez vous présenter au comité, et après, commencer votre présentation.

**M<sup>me</sup> Denise Chevrier :** Je m'appelle Denise Chevrier et je suis vice-présidente du Service d'entraide communautaire.

**M. Pierre Périard :** Je suis Pierre Périard. Je suis le directeur général du Service d'entraide communautaire.

**M<sup>me</sup> Chevrier :** Vous en avez une copie ?

**Le Président :** Encore une fois, il y a deux documents, dont la déclaration que vous allez faire maintenant.

**M<sup>me</sup> Chevrier :** C'est ça.

Les représentants du Service d'entraide communautaire pour les aînées et aînés francophones désirent remercier les membres du comité avisé sur le développement social, qui nous donne l'occasion d'exprimer notre point de vue sur le projet de loi 173 concernant la réforme des soins de longue durée.

La réforme des soins de longue durée provoque une restructuration radicale de la prestation des services aux aînés et aux handicapés de l'Ontario. Cette réforme vise à intégrer les services de santé et services sociaux et à faciliter l'accès aux services pour tous les consommateurs de l'Ontario. Dans le cadre de cette réforme, le projet de loi 173 énonce des directives pour la mise sur pied de nouveaux organismes dits organismes de services polyvalents, soit OSP.

Ce projet de loi vise à simplifier l'accès aux services communautaires par la mise sur pied d'un système à accès unique, à augmenter la participation des usagers à la prise de décisions et à la planification concernant la prestation des services, et à accroître la responsabilité des organismes prestataires de services. En outre, la nouvelle loi reconnaît officiellement que les conseils régionaux de santé ont le mandat de diriger la planification locale des services de soins de longue durée.

Il est important de souligner que le Service d'entraide communautaire pour les aînées et aînés francophones appuie les objets de la loi énoncés à la partie 1 du projet de loi 173. Chaque affirmation place l'individu au centre et lui accorde un rôle important dans le réseau de la

santé. Veiller, améliorer, reconnaître, simplifier, promouvoir et encourager sont conformes aux principes énoncés dans le document intitulé *Partenariats dans les soins de longue durée* : Un nouveau moyen de planifier, d'administrer et d'offrir des services et du soutien communautaire, dans lequel les objectifs qui ont trait aux OSP veulent respecter, appuyer, intégrer, assurer, encourager et élaborer.

Le Service d'entraide communautaire appuie également la déclaration des droits de la personne qui reçoit des services communautaires. Ces droits énoncés à la partie 3 sont toujours conformes aux principes et aux objectifs de respecter et appuyer le désir de dignité, de bien-être et d'autonomie des gens, d'assurer une plus grande participation des clients et un plus grand contrôle dans la planification et la prestation des services.

Le Service d'entraide communautaire est un organisme à but non lucratif qui assure des services de soutien à domicile aux aînées et aînés francophones de 60 ans et plus de la région d'Ottawa-Carleton, et dont la mission est de favoriser leur bien-être physique, social, affectif et spirituel ; permettre aux personnes âgées francophones de demeurer le plus longtemps possible à domicile et dans un environnement qui leur est familier pour ainsi retarder le processus d'institutionnalisation ; inciter les aînées et aînés francophones à demeurer actifs dans leur communauté ; maintenir une qualité de vie le plus longtemps possible ; et assurer des services de qualité de manière efficace. Le Service d'entraide communautaire offre, depuis 1974, soit une période de 20 ans, des services bénévoles (visites amicales, télé-jase, télé-bonjour, escorte, épicerie-bus) et des services à coût minime (entretien ménager, travaux d'entretien, service de répit et transport).

Afin d'amorcer un processus de réflexion interne sur la réforme des soins de longue durée, le conseil d'administration du Service d'entraide communautaire a créé un comité ad hoc. Dans un document intitulé *Pour un organisme de services polyvalents francophone Ottawa-Carleton*, dont vous avez une copie, le comité a consigné notre mission, notre philosophie, nos valeurs fondamentales, les services offerts et le territoire desservi. Il a également fait une synthèse des activités des quatre dernières années et a inclus une vue d'ensemble de la population âgée francophone d'Ottawa-Carleton en relation avec l'éventail complet des services énumérés aux pages 16 et 17 dans le document intitulé *Partenariats dans les soins de longue durée*.

Parce que les planificateurs de la réforme des soins de longue durée s'attendent à ce que chaque organisme de services polyvalents offre un éventail complet de services, le Service d'entraide communautaire a entrepris des pourparlers et des rencontres avec les organismes francophones qui offrent actuellement des services à la population francophone. Après quelques consultations auprès de ces organismes, il nous apparaît évident qu'il serait facile de mettre sur pied un organisme de services polyvalents francophone en utilisant les organismes francophones déjà en place sur le territoire.

Les aînés francophones de la capitale nationale éprouvent beaucoup d'incertitudes et d'inquiétudes face à ce

projet de loi concernant les soins de longue durée. Ils décèlent présentement aucune assurance, quant à la protection des services en français dans le projet de loi, au niveau de la prestation des services aux consommateurs. Leurs inquiétudes se traduisent par deux questions :

(1) Comment cette réforme de soins de longue durée protégera-t-elle les services en français ?

(2) Est-ce que la nouvelle loi proposée garantira la protection des services en français ?

Le Service d'entraide communautaire désire réitérer certains principes fondamentaux qui devraient guider la prestation des services en français au sein de l'organisme de services polyvalents. La communauté francophone d'Ottawa-Carleton, qui compte la plus forte concentration de francophones dans ses rangs, soit 120 000 personnes, a réussi à développer un réseau de services qui lui permet de rejoindre et de servir de façon adéquate la population âgée francophone. Bien qu'il reste des améliorations à apporter, il n'en demeure pas moins que ce réseau de services qui a mis beaucoup de temps à se bâtir a su répondre jusqu'ici aux besoins de la population âgée francophone d'Ottawa-Carleton. Il est important de développer la prestation des services en français en misant sur les acquis du réseau qui a été mis en place par la communauté francophone de la capitale nationale au cours des 20 dernières années.

#### 1150

Le Service d'entraide communautaire croit qu'il est important de reconnaître le principe général suivant : les aînées et aînés francophones ont le droit fondamental d'être servis dans leur langue, peu importe leur lieu de résidence à Ottawa-Carleton.

Le Service d'entraide communautaire croit également que la communauté francophone a le droit et la responsabilité d'assurer la planification communautaire, la gestion et la prestation des services qui sont destinés aux personnes âgées d'expression française d'Ottawa-Carleton.

La population francophone d'Ottawa-Carleton n'a pas du tout senti de considération envers sa langue et sa culture dans cette réforme de soins de longue durée. Il est tout à fait raisonnable et attendu qu'il y ait dans la région d'Ottawa-Carleton un organisme de services polyvalents francophone qui offrira des services en français.

Au nom de tous ses membres, ses bénévoles, ses bénéficiaires et de la population aînée francophone d'Ottawa-Carleton, le Service d'entraide communautaire pour les aînées et aînés francophones demande à la ministre de la Santé que le projet de loi 173 concernant les soins de longue durée soit amendé pour garantir l'inclusion des services en français dans la Loi sur les soins de longue durée afin de permettre la création d'un organisme de services polyvalents francophone dans la région de la capitale nationale, protégeant ainsi les droits des francophones.

Les besoins de la population aînée francophone d'Ottawa-Carleton seront mieux palliés par un OSP francophone. Le Service d'entraide communautaire préconise la nécessité d'établir des politiques claires à ce sujet. Sinon, un aîné francophone essayant d'obtenir des services d'un OSP qui n'est pas francophone sera ballotté d'un presta-

teur offrant des services en français à d'autres qui n'en offrent pas. Autrement, comment cette réforme se prouvera-t-elle différente de la situation connue actuellement par le consommateur francophone aîné ?

Afin de respecter la volonté exprimée par le gouvernement de fournir ces services en français, la population francophone a le droit de s'attendre à ce que la planification des services de soins de longue durée reconnaisse et remplisse l'engagement concernant la prestation des services en français. De plus, la prestation de ces services s'alliera aux facteurs de gestion de cas en français, comme l'information sur les services, l'évaluation des besoins, la détermination de l'admissibilité aux services etc. Un intervenant francophone crée un dossier en français pour un client francophone dans un OSP administré entièrement en français.

Pour conclure, nous vous remercions de l'attention que vous apporterez à ces recommandations.

**Le Président :** Merci pour la présentation. Monsieur McGuinty.

**M. McGuinty :** Merci, monsieur, madame, pour être venus devant nous autres aujourd'hui. Je suis très content que vous avez pris le temps pour venir nous présenter cette présentation de la part de notre francophonie, une partie très importante de notre population ici à Ottawa-Carleton.

Je pense que vous posez de très bonnes questions ici, en demandant ce que le projet de loi 173 va faire pour protéger les intérêts de nos aînés francophones. Les deux questions se trouvent en bas de la page 3. J'ai posé ces mêmes questions à l'adjoint parlementaire pour qu'il puisse nous donner la réponse, parce que je trouve que ce sont de très bonnes questions.

Alors, à l'adjoint parlementaire, les deux questions se trouvent en bas de la page 3. Premièrement, comment cette réforme de soins de longue durée protégera-t-elle les services en français ? Deuxièmement, est-ce que la nouvelle loi proposée garantira la protection des services en français ?

**Le Président :** L'adjoint parlementaire. Parliamentary assistant.

**Mr Wessinger:** I'm going to ask our policy person to respond to the more specific details on how this will be achieved.

**Mr Quirt:** In areas of the province designated under the French Language Services Act, it's the intention of the minister to list one or more multiservice agencies under the French Language Services Act, requiring that MSA to deliver services in French. It wouldn't necessarily be all multiservice agencies in a designated area, but at least one or an appropriate number will be designated under that act and they will be required to meet the conditions of the French Language Services Act in that regard.

**Ms Gigantes:** What would that mean in Ottawa-Carleton?

**Mr Quirt:** It would depend on the planning of the local long-term care subcommittee. I'm not sure how many multiservice agencies the district health council will recommend to the Minister of Health be established in

Ottawa-Carleton, but clearly one or more of the MSAs that would be recommended would be designated under the French Language Services Act.

It's her intention to ensure that in every designated area of the province there are services available in French from an MSA, and she has indicated to provincial associations that have raised that issue her intention to list MSAs under that bill to ensure that all the provisions of the bill apply. She has also made it clear to district health councils that are planning for services in areas that are designated that they need to pay particular attention to planning for the needs of francophone Ontarians. No doubt DHCs need to take that into account in a number of their activities, but specifically with respect to long-term care she expects the proposals to deal with the needs of francophone community members.

**Le Président :** Est-ce que vous voulez ajouter quelque chose ?

**M. McGuinty :** Est-ce que ça vous donne du confort ?

**M. Périard :** Je reviens aux commentaires que nous avons faits, que si la population désire un OSP, ce qu'on appelle un organisme de services polyvalents francophones, alors, à ce moment-là il y aura absolument moyen qu'il y ait un OSP francophone dans la région. Si la population, la communauté francophone désire un OSP francophone pour répondre à ses besoins, alors, à ce moment-là ça va être une possibilité.

**Le Président :** Si je comprends bien ce qu'on dit, c'est que la Ministre a dit qu'on va créer un OSP francophone, au moins un, mais ça va dépendre de la planification qu'on va faire, par exemple, dans la région d'Ottawa-Carleton.

**M<sup>me</sup> Chevrier :** Il existe déjà un OSP francophone dans le comté de Prescott et Russell, mais la population francophone d'Ottawa est quand même supérieure à cette population, et on trouve que la région d'Ottawa devrait être munie d'un service OSP francophone.

**Le Président :** Bon. Au nom des membres du comité, j'aimerais vous remercier encore une fois d'être venus ici ce matin. Merci beaucoup.

With that, members of the committee, we will break for lunch. We will reconvene at 1:30 here.

*The committee recessed from 1200 to 1334.*

#### UNION OF ONTARIO INDIANS

**The Chair:** We will move immediately to our presenter, from the Union of Ontario Indians, Dr Alan Roy, the health director, and there may be someone else as well.

**Dr Alan Roy:** My name's Alan Roy. I'm the health director at the union, and to my left is deputy grand chief of the Anishinabek Nation, the band member from Saugeen First Nation.

What I'm going to do is give you a little background material, just talk to you, besides what I have in the brief, so you'll understand why we're coming in front of you today and what our credentials are in involving ourselves in this long-term care review.

From 1992 to 1994 we conducted a comprehensive

consultation on long-term care needs within our communities. We published that report and we've given it to the Ontario government. They've had it for over a year. We've done extensive consultation on an aboriginal health policy for Ontario and we've been involved in drafting that policy for the past five years. That's completed now and we're in the implementation phase.

We've just drafted a framework agreement between the Ontario government and the Anishinabek Nation to implement the aboriginal health policy and essentially build seven community health centres in seven strategic areas within the union. That becomes important because that's where we think we'll locate our multiservice agencies. The long-term care facilities will be part of our aboriginal health facilities and our outreach programs to the communities.

There are 41 first nations within the Anishinabek Nation, and they're essentially the Ojibway communities around the Great Lakes. So essentially we break those down into seven strategic areas. It's going to overlap with the non-Indians' territories, but we've always anticipated, and I think the Ontario government understood, that we were expecting a parallel system that would be designed by us, implemented by us, evaluated by us and essentially staffed by our own people to meet the needs of our own clients.

In order to facilitate the implementation of Bill 173 and the long-term care within the Anishinabek Nation, we've done the following things: We've established an Anishinabek health commission with representation from each of those seven strategic areas. We have an Anishinabek training institute. We have seven sites for the aboriginal community health centres. We've done a complete costing of the long-term care programming and the multiservice agencies that we will require. We've signed a protocol that we've developed between the off-reserve and our first nations on reserve for service delivery. The multiservice agency boards will be appointed by the tribal councils in those strategic areas and they'll be accountable to the Anishinabek Nation. So, obviously, we've thought a lot about what we're doing.

We have a problem with the legislation and I'm going to ask the deputy grand chief to go through a letter that was written between the grand chief of our nation and the Chairman of this committee.

**Deputy Grand Chief Vernon Roote:** Thank you very much. This letter is regarding Bill 173 and the letter is addressed to you, Mr Chairman:

"The provincial reforms to the services for the elderly, frail and disabled have a major impact at the first nation level in the Anishinabek territory. The level of service, the quality, the cultural appropriateness and accessibility are issues of concern. In first nations, the only community support service offered to the frail, elderly or disabled is the homemaker and/or home support program. Both these programs have been chronically underfunded. It's been very reassuring to have the issue respected in Bill 173 when no amendments were made to the Homemakers and Nurses Services Act.

"The area that requires an amendment to the current wording is section 62.5(a) and (b): the use of the word

'may' be changed to the word 'will' or 'shall.' The intent of section 62 is to clarify the mandate to the district health council in their geographic areas. District health councils should be directed to allow first nations to assert their jurisdictional issues. Aboriginal health and social service authorities are accountable to tribal councils and ultimately first nations. First nations will have an opportunity to formally opt into a district health council by passing a formal band council resolution. The Anishinabek proposed changes will clarify that district health councils are to back away from planning, managing and delivery of services when these functions are the responsibility of an aboriginal community or organization.

"The Anishinabek nation has developed a health commission which will be funded in part by Health Canada. Needless to say, if district health councils are occupying a field in respect to health services for the purpose of surveys delivery, planning and management, there will not only be duplication of services but room for misinterpretation of each party's role and responsibilities and create further misunderstandings between first nations and the government of Ontario.

"In addition, the aboriginal health policy initiative, that has been approved by the Ontario cabinet, vision statement speaks of self-determination in health being supported by appropriate levels of financial and human resources for aboriginal designed, developed and delivered programs and services that respect and promote community responsibility, autonomy and local control.

"In summary, the standing committee's support and advancement of amending 'may' to 'will' or 'shall' in section 62.5(a) and (b) will provide for consistency in the provincial approach to health services at first nations."

The letter was signed by our grand council chief, who couldn't make it, and I signed for him. I'm the deputy grand chief of the Anishinabek nation.

1340

**Dr Roy:** It's the essential section in the bill that we want. We want the standing committee to understand that district health councils cannot intrude into the planning and design of these. Therefore, it's going to be incumbent on the minister and the legislation to set up a situation where we'll be able to set up our own multiservice agencies, be able to appoint our own people and have those people accountable to our own structures within our area.

There is some minor stuff in the legislation that we pointed out.

**The Chair:** Did you wish to complete the presentation and then we'll come back to this as well?

**Dr Roy:** Sure.

**The Chair:** Okay, fine. Go ahead and finish your comments, because I know the parliamentary assistant wanted to address—

**Dr Roy:** I think the brief speaks for itself. They're very pointed comments.

**The Chair:** Then we might do that, because it might serve everyone's interests more if we can just explore the questions that were raised in the letter. I'll turn to the parliamentary assistant.

**Mr Wessenger:** Thank you very much for your presentation. I'm going to ask legal counsel to respond with respect to the legal reasons for the wording in the bill with respect to the "may" and "shall."

**Ms Gail Czukar:** It was our understanding in drafting the bill, in consultation with Carrie Hayward, the person in the Ministry of Health I'm sure you're familiar with who deals with these issues, that we needed to make it as broad and general as possible, because aboriginal health authorities or whatever they may be called are not yet in existence and aren't set up. There's no formal process for when an aboriginal health authority would take over the functions of the DHC and so on. It was left permissive so the minister could do it at the appropriate time and at the appropriate level. The intention was, of course, that as soon as there was an authority in place to do that kind of thing, the minister would tell the district health council not to exercise its authority in that area. That's the reason it's left permissive.

**The Chair:** Just some clarification on this: I have Mr McGuinty and Ms Gigantes, and then I'll throw it back to you.

**Mr McGuinty:** I'm not sure how much comfort legal counsel's response lends to your concerns, but it doesn't lend a great deal to the discomfort it presents for me.

This government has entered into a memorandum of understanding with our first nations. It's subsequently been amended and I think the best thinking of the day compels us to move step by step towards self-government. It would seem to me that this is a logical step along that path to allow our first nations people to assess their particular needs and to meet those needs in the best way they see fit.

I guess I really don't have a question, it's just a comment. What we're doing is leaving the door open for the minister in a very strict permissive way. There's no obligation, there's no deadline found within the legislation, nothing there that compels the minister to take that final step which gives you, as I say, another step along the road to self-government. If you want to comment, then please feel free to do so.

**The Chair:** Perhaps I'll just allow Ms Gigantes to put her thought or question and then you can respond.

**Ms Gigantes:** I'd like to ask legal counsel, if I could, how the "if" in subsection (5) relates to the "may," because there is an "if" which seems to establish the premises under which the minister might. The question is if the "if" is satisfied, should we be changing it to "should" instead of "might"? That certainly legally provides some qualification. I have a follow-up question.

**Ms Czukar:** That's right, it does. I guess the issue is whether the health—

**The Chair:** Excuse me, could I just ask you, because we're dealing with the clause, to read it so we at least in our minds have a sense of the "if," "might," "should," "will," "may."

**Ms Czukar:** Under section 62, proposed subsection 8.1(5) says:

"If health services for an aboriginal community in a district health council's geographic area are planned,

managed or delivered by the aboriginal community or by an aboriginal organization, or if"—this is not that exciting—"resources for health services for the aboriginal community are allocated by the aboriginal community or by an aboriginal organization, the minister

"(a) may direct the district health council not to exercise one or more of its functions with respect to the aboriginal community, despite subsection (4)" which articulates the DHC's functions, "and

"(b) may direct the district health council" essentially "to cooperate with the aboriginal" health authority to plan and so on.

So the preconditions that are set in the first part that Ms Gigantes referred to are preconditions to that direction being given by the minister to the district health council not performing its functions in that area, but there are obviously a number of ways that can happen. As I said earlier, that's why it was drafted generally, because it's my understanding that there are a number of arrangements possible in different aboriginal communities in different DHC areas where in some areas you might have an actual aboriginal health authority. In other areas, it may be the aboriginal community itself and they may want to do more or less planning, more or less delivery. So it was to allow for different stages of development and different stages of readiness to take over functions of DHCs and to compel DHCs to cooperate in areas where that would be the requirement that it was left permissive.

**Ms Gigantes:** Again I'll ask legal counsel's help here. The tests set out in subsection (5) under the ifs are very low.

**Ms Czukar:** That's right.

**Ms Gigantes:** It says that the minister "may" if, for example, the level of involvement of the aboriginal community or aboriginal organization is merely to plan, because it's plan, manage or deliver, so you might be delivering one service or you might be planning three services. The minister still has the authority under the act then to say to the district health council, "Step aside; this community is going to organize its own pattern of service delivery."

The way I read it, and legal counsel might help, is that there's been a deliberate attempt to keep the ifs tests very low and say that even on a very low test of involvement by an organization or the community, the aboriginal community, the minister may go ahead and tell the related district health council to step aside here. That's my reading. I don't know if I've got that right.

1350

**The Chair:** Just before asking you to respond to that, Ms Sullivan, you had a question just on that meaning as well, so can we get that on the table and then we can let our presenters respond.

**Mrs Sullivan:** My question is also with respect to interpretation, although of a different section, in that I'm concerned about whether in fact first nations can be designated as multiservice agencies, given that an agency such as the Red Cross, which is incorporated on a different basis, cannot be so designated and I would suspect that the same criterion would apply to first

nations or to the off-reserve aboriginal groups. Similarly, if to get around that the ministry contemplates an aboriginal health council or an aboriginal health authority to become the DHC, can the DHC appoint itself as an MSA?

**The Chair:** We have those questions of interpretation. Do you want to comment on either or both of those, and then I'll ask the parliamentary assistant to respond, or legal counsel, as the case may be.

**Dr Roy:** Notwithstanding the answer we have from legal counsel, I think there are some things here that are historical in Ontario in the evolution of district health councils in the field. They tend to take over and get in there and plan, and we're saying the district health councils should not have carte blanche to move into an area and include aboriginals in their statistics, which they historically have done. There should be something that guarantees the non-involvement of district health councils until aboriginal communities invite them to be involved. That's why we suggested the wording that Deputy Grand Chief Vern Roote suggested.

The other thing is, there's nothing in the premise or the initial parts of the legislation to indicate the acceptance of a parallel structure. We've gone to a great deal of trouble to do the basic consultation and planning involved here, and I'm afraid the legislation just doesn't reflect the reality of what we prepared ourselves for. I'm wondering if down the road a minister—it may not be the same minister as today—would read the legislation and say, "We can only have one multiservice agency in a particular territory and there cannot be a split jurisdiction"—or whatever—"between the non-Indian and the aboriginal."

**Mr Wessinger:** I'll ask legal counsel to answer those questions she feels she can deal with, and if she wants to throw some back to me, I'm conducive.

**Ms Czukar:** It's my understanding that there is a consultation and a discussion process going on with various first nations' groups as to how long-term care services will be delivered in those communities and that that's a separate process and the legislation is not meant to dictate any form of service delivery with respect to them or say anything about that process. It's going to go on and it is going to produce its own results. So the provision on district health councils was put here, as I said, to try to create the opportunity for aboriginal health authorities to take over those functions as soon as possible when they were in place. The other processes that you've been engaging in are anticipated to go on and nothing will be superimposed on those until those discussions are concluded.

**Dr Roy:** One last comment then: We know that during the last two years many district health councils in Ontario used aboriginal statistics in their submissions to the ministry for the development of their long-term care programming, against the wishes of many of the first nations whose statistics they used. I think it may have been a reason why Ms Hayward wanted to put something into the legislation. I'm saying it doesn't go far enough, and I'm quite adamant about that.

**The Chair:** You've made your presentation before the committee and I think your points have been clearly

made. We thank you very much and certainly will be reviewing that along with everything else as we go about our deliberations.

#### REGIONAL MUNICIPALITY OF OTTAWA-CARLETON

**The Chair:** I call upon the representatives from the regional municipality of Ottawa-Carleton. Welcome to the committee, regional chair. We're glad you could come to the committee today.

**Mr Peter Clark:** My name is Peter Clark. I'm chair of the regional municipality of Ottawa-Carleton. With me is Mr Garry Armstrong, who is the chief in charge of all the homes for the aged in the region. Garry has been a long-time member of regional staff and certainly is well known in the community in terms of the care of the aging. Thank you for the opportunity to address you. This bill is of major interest to the regional municipality of Ottawa-Carleton. It's also of major interest to all the regional chairmen across this province and the Association of Municipalities of Ontario.

We generally believe that there is a need to improve the system of long-term care. We think in this community the priorities are information access and coordination of services. We believe there is an excellent system in place in this community already, and we want to build on that. We've been working in partnership with the district health council and other planning bodies in the region to look at this bill, to talk about it, to try to come to terms with some of the principles.

We as a region are also involved in community planning of health and social services. In other words, we have a fairly broad mandate in this area as well. Right now, for your information, the region administers 92% of the \$61.6 million of MSA-type services in Ottawa-Carleton. Regional home care serves over 7,000 clients daily. We operate three homes for the aged. We operate community support programs. We provide a wide range of social services above the minimum standards that the province sets.

We believe the municipal option for MSA sponsorship should be the same as every other one so that in any given community, what's right for that community can be addressed, not master planned from wherever. We believe the district health council must be able to consider all these options on an equal basis. In Ottawa-Carleton, the DHC discussion paper clearly lays out municipal sponsorship as an option for the community to consider. The region supports this approach.

Bill 173 restricts the consideration of options, so we strongly recommend the removal of subsection 11(3) so that communities can have the ability and the flexibility to consider all the options in a thoughtful, inclusive process. Why restrict it in the way it's been restricted?

Finally, I should speak to the notion of accountability. Right now, councillors are elected by the citizens and are accountable to them. Special-purpose bodies do not have the same kind of accountability. Local government is close to the constituents and understands the service needs and in a great number of cases is supplementing the broader picture. We feel we have an ability to understand diversity of community and deliver services

that meet the needs of our ethnocultural communities and all other communities within this region. We already have a strong commitment to public consultation and have done considerable consultation with the public on this matter, and we do deliver services in a collaborative, community-based planning model.

I guess I'd like to sum up after Garry makes a presentation so we can sort of isolate and specify certain points, and then we'll be willing to discuss anything you wish.

1400

**Mr Garry Armstrong:** I'll speak from our brief to two issues that are included in the brief, the role of volunteers and the purchase of service. From an opportunity I had as past president of the Ottawa-Carleton United Way and representative of the United Way of Ontario, I met, with a group from United Ways across the province, with the minister this past spring. Two things: One is to thank the minister for that opportunity, and perhaps to reiterate the views of not only United Way volunteers and agencies that are potentially affected—and I realize it's potentially—but the other volunteers and organizations that have come forward during these hearings.

I believe that, as you will see or have seen already from the presentations here in Ottawa-Carleton, we have a very strong volunteer commitment in Ottawa-Carleton, particularly evident, I think, in the district health council, the council on aging is another strong body, the social planning council and the United Way. So this is an issue of very deep concern for us and certainly for the regional municipality as well. I think whatever the outcome of the model that is developed, it certainly is an area that we share with others across the province that we have to be very careful of in terms of the development of an MSA model.

The second issue, then, would be the purchase of service, or the limit on purchase of service. I think the concern that is expressed not only by the region, by other presenters, but even by the council on aging and the district health council is the limit issue, that every community is different. We have a commitment that the region is strongly supporting to let the community decide. Our concern is that 20% is an appropriate target perhaps in some communities. What we are suggesting is that the limits contained in section 13 be removed. In fact, the removal of section 13 would allow this community, and the process is well under way, to develop a model that is not as one-stop, if you want, in the pejorative sense, not in the sense of service, that would eliminate some tremendous services that are being provided by organizations and the obvious potential impact again on volunteers.

We as a municipality, as a regional municipality, have participated with the district health council in its studies to date. The strongest issue and the number one priority in Ottawa-Carleton at this point in time remains information referral and one-stop access, and that is a priority the district health council is putting on that we are strongly supporting.

With home care, we obviously have a great concern about the issue of purchase of service. As Chair Clark has

indicated, we purchase most of the services, and I think in addressing that issue of large government or bureaucracy that I know has been raised and what that means to different people, we as a municipality have not gone out with any intent to increase our staff or the services we provide directly. In fact, our approach has always been to work with organizations, such as the district health council, with provincial authorities and with local volunteers to determine what services are needed, and in most cases, in a great number of cases, we purchase them on behalf of service providers, and we feel that model has worked exceptionally well.

We are very aware of the costs that have been identified by some groups in terms of creating a new organization if that is the case. We would prefer building on what we have and our experience. For example, the region did assume the responsibilities of the board of health some years ago and are well aware of the issues of unions and negotiations etc that go along with that. On behalf of, and at the request of the province as well, we assumed responsibility for Centre d'accueil Champlain, a home for the aged in Ontario. Again, the reason I mention these is that these are not issues we pursued but were done on the basis of community consultation and in the best interest of the community, and the recommendations came from other bodies to the regional municipality of Ottawa-Carleton.

Finally, I think in terms of governing models, as chair Clark referred to, we have an extensive consultation process in place in Ottawa-Carleton and in many areas use volunteers, including the district health council. For example, for many years we have funded capital projects in hospitals only at the approval of the district health council, and similarly in many of these services that we provide we depend on volunteers and community-based organizations to assist us in determining what it is that we provide as a municipality.

So those two issues then: One is, again, supportive of all of the comments on volunteers; and secondly, the real concern about a limit of 20%, even recognizing that it's four years down the road. Let this community that this region will support determine that limit, whether we ensure they're provided or we provide them ourselves, as the section says.

**Mr Clark:** In closing, I guess we are requesting that the committee support local planning by removing subsections 11(3) and sections 13 and 15 from the bill so that a municipal option can be equitably assessed along with all the others. If the choice of the community is regional government, we believe we are well suited to provide MSA services, not directly but through the brokerage models that have been described by Garry. It's hard for us to believe in times of fiscal restraint that a government could consider ignoring the infrastructure, information systems and expertise that the region currently has, because it will be very expensive to replicate.

Regional council has supported examining the feasibility of administering a pilot MSA in Ottawa-Carleton, if there's community support, to assist speedy implementation. The uncertainty in the long-term care sector must be put to an end quickly. Around this table we might

understand the process, but certainly among clients, staff, agencies and children of people who are in care there's a lot of uncertainty, and that's not just in Ottawa-Carleton, that's across the whole province. We need answers and we need solutions and we need them now.

In summary, we've got a system here that works well. Certainly it can be improved, and we've pointed out areas we feel are priorities, but we don't think there's any need to replace it in its entirety with a special-purpose body that wouldn't be accountable and that would eliminate volunteers in the community, and we believe that it's up to you to let this community decide.

**Mr Sterling:** Thank you very much for making your presentation, Mr Clark and Mr Armstrong. I might also add that Mr Armstrong is a retiring member of the Carleton Board of Education, so he not only works for a government but he also is responsible for the other side, the political side, at this time.

I'm going to make it a two-part question because I've only got one question. You say that you control 92% of a certain number of services. Is that your interpretation of all of the services that would be administered under an MSA as proposed in Bill 173?

**Mr Clark:** Yes.

**Mr Sterling:** The second part of my question is, I don't disagree with you in terms of the political accountability. I am concerned about how an MSA is elected or chosen and what its accountability is to the people. Would it not make some sense for areas which I represent, as you both know, like the township of Osgoode or the township of Rideau, where Garry resides, to have the local municipality as an MSA for some part of services, rather than the region, because in some of those municipalities, like the township of Osgoode, they relate far more closely to the local government than they do to the regional government.

**Mr Clark:** Well, I would agree about the relationship, but in terms of the bulk of the services, Osgoode was among the regional councils requesting that the region take over home care. It used to be that each municipality would sort of set a limit on what it expected to spend on home care and the region would deliver the service anyway. I'm not sure you gain a lot from where you're headed with that, but I think you're thinking of things like the Osgoode Care Centre, which is a fine facility. It's developed in Osgoode, serves the needs of the local area and would still operate under this thing. As far as I know, this wouldn't affect it.

1410

In other words, the services that are part of the network of services in a region would still be there and still be operated by the operators, the way we envision it. Correct me if I'm not being accurate enough. Jump in when you feel the urge.

**Mr Jim Wilson:** Well, except that it is affected. It's a nursing home, the Osgoode?

**Mr Clark:** Yes, it is.

**Mr Jim Wilson:** The PCS moves under the MSA and admissions—I assume your PCS is attached to the region right now.

**Mr Armstrong:** No, it's independent. Non-profit—

**Mr Jim Wilson:** It's independent. Because I know mine, in Simcoe county, moved to the county level. It's independent but it's essentially got the county players on it and that will move under the MSA and there's very much concern among most municipalities that they lose that also. Do you have any concerns about that?

**Mr Clark:** We haven't had a lot of people, but fire away.

**Mr Armstrong:** I can speak to the placement coordination service here locally. I served as president for two years and we're actively involved. I think the concern we have with the PCS locally is probably similar to other areas of the province. We've always had a volunteer board. We developed our system locally, with municipal involvement and with all of the institutions involved. We developed our forms that we all agreed to utilize.

We are running into some problems now that have to do with the additional responsibilities put on the local PCS in terms of the admission process. We are concerned that if this process goes on too long, in that we are underbedded in this area in the long-term care field, the admission process is going to become a major problem for us.

As an institution, however, we've always worked very closely and we've always had the same waiting lists, all amalgamated under PCS.

**Ms Gigantes:** I'd like to go to the question of brokerage of volunteers and the relationship to setting priorities at the local level. We're in an area in which, as I understand it, about 70% or more than 70% of the services that are provided in the community that we call long-term care services are provided by private for-profit organizations. That being the case, the extent of volunteer involvement in over 70% of the services is probably lower than one would find if, for example, the ratios were reversed and 70% were in the non-profit sector.

I'd like your comment on that and your comment too on what that structure of service provision in Ottawa-Carleton means when you come to try and assess, on a community level, what the priorities are for service. Obviously, if you're dependent currently on 70% from the private sector, then you're going to tend to assess what the priority for service is, based on what's available, and that's out of the private sector. The MSA proposal, it seems to me, offers an alternative, which is that you can on a non-profit basis build up services which the community may assess as having a higher priority than the private sector might.

**Mr Armstrong:** The document itself in fact recommends that the responsibility of the district health council is changed significantly in terms of making recognition of allocations of resources; in other words, what shall be provided etc, and we've worked very carefully with the DHC.

My experience with profit-making organizations in Ottawa-Carleton has been extremely positive. I refer particularly to the nursing home sector. In fact, the volunteers within that sector, since we meet them regular-

ly in the non-profit homes, are exemplary in terms of their commitment to service, and I would suggest that it's similarly the case. The only difference would be in the makeup of boards of directors, perhaps, of non-profit as opposed to profit providers of service in the community. But I think in terms of the commitment of the volunteer, it's been strong, in my experience with the ones I've worked with, in the profit sector as well as the non-profit.

It's obviously an issue that is paramount. I have greater concerns about—and I realize that it may be larger in some communities than others. It seems to be the fear out there that if we look at one large organization, and I know it's a non-profit board etc, the concerns are that volunteers will be lost. I think with any change, that has to be our number one priority, to ensure that we do maintain them.

**Mr Clark:** Just briefly, I think that the for-profit sector does stimulate as much as possible volunteerism in this community and I suggest that the other model probably would tend to destimulate volunteerism.

**Ms Gigantes:** Hospitals compared to nursing homes?

**Mr Clark:** No, we're not talking about hospitals.

**Ms Gigantes:** But if you look in—

**Mr Clark:** Community agencies.

**Ms Gigantes:** —other areas of service, institutional areas of service, certainly hospitals with non-profit boards don't seem to have a problem stimulating the use of volunteer service.

**Mrs O'Neill:** You brought up the very fundamental question of accountability. We had a brief discussion this morning about what an MSA board would look like and how it would be elected, and it's certainly not the kind of election that the councillors in Ottawa-Carleton are going to go through in a few weeks.

My question is really a two-part question. I'm very pleased that you brought forward the idea again, which has come forward more than once today, of a pilot project, and that you volunteered for that. You talked about costing. We had the Metro council in Toronto come before us, and it has a connection directly with the United Way, as we seem to have here. They mentioned that the finance subcommittee of the long-term care committee of the DHC in Toronto had only met twice and had to fold because it had no data.

I'm wondering if you had a similar experience here with costing, that you have no data, that you can't cost this out. And then secondly, you have brought forward something I haven't seen in any other brief. You have stated on page 6, "The region is concerned that services to some clients, specifically those on social assistance and low-income earners, may be lost in this reorganization." Could you say a little bit about either of those things?

**Mr Clark:** I'm going to defer to our expert here in the details.

**Mr Armstrong:** I think perhaps in the former, in terms of the costing, the district health council and long-term care committee certainly haven't reached that stage. Perhaps that can be addressed when they make their presentation. We did cost out the one-stop shopping option that we proposed as the Ottawa-Carleton region

some years ago. It was evident, even at that time, that there were going to be some significant costs involved in setting up a system of simply information referral.

As a result, that issue still has to be determined, and it's very difficult to determine the cost of an organization until you define what it is. We can certainly tell you what it costs to run the home care program and the placement coordination service; those data are there, and they're not necessarily add-on costs. I think it's when you then start building the organization that you have to determine what other costs are involved.

In terms of the question of social services and the impact on that group, I think our concern is, since we provide major services, obviously, to low-income people in Ottawa-Carleton, a very strong social services community, that we are concerned about that issue of the amalgamation of social services and health and whether or not the social services component of the low income would be in fact be hurt, certainly in the short term, as we put our priorities perhaps more on the health side.

**Mr Clark:** Essentially, I think he's tapped most of it. We have a social planning council, a district health council, certainly a very healthy United Way organization.

**Mrs O'Neill:** Twelve hundred strong this morning, Peter.

**Mr Clark:** All of these people are working very hard towards making sure that the most efficient and beneficial service model in this community is used, because obviously, if you're more efficient you're able, with the same resources, to apply more help, more services to the community. So it wouldn't be any mystery that that's the objective.

**The Chair:** I know we could go on with more questions, but I'm afraid our time is up. We thank you again for coming before the committee.

**Mr Clark:** You have a tough job. Thank you.

1420

BETTY MARGESON

**The Chair:** I call on Ms Betty Margeson. Welcome to the committee.

**Ms Betty Margeson:** I am here as a care giver, or more accurately, at least for four years, as the daughter of a care giver. My mother and father, one or both, have been on home care since 1989. My father died in June 1993, two months short of his 81st birthday, and my widowed mother is now living with me.

My perspective this afternoon is to provide quality health care to the elderly as much as possible in a non-institutional setting. From my observations with my parents and from the work experience that I have working with senior management, working with middle management, developing policy and procedures in the department of supply and services, working on computer project teams as a documenter on application teams, I have used some of these work skills to observe what's happened as my parents have aged and, as I say, one has died.

I have three specific solutions to offer:

(1) To replace the existing personal maid service

structure of home care housekeeping with (a) designated routes between houses within a neighbourhood and (b) on-the-premises housekeeping in apartment buildings;

(2) To allocate the savings to rehabilitation services to prolong their independence;

(3) To dovetail mental health time for the care giver with delivery of rehabilitation services.

I am going to skip to the specifics and come back to the benefits.

First of all, I would like to replace the personal maid service delivery system. At the moment, when you apply for home care, the client chooses the day and time of delivery of housekeeping services. The housekeeper comes on different days to people who live within the same neighbourhood, sometimes within the same block or two blocks.

In an apartment building such as the Tannenhof seniors' co-op where my parents lived, there is the same scenario, compounded by the density of population. So there are three housekeepers all in the laundry room at the same time, three housekeepers at the same neighbourhood grocery store and three housekeepers vacuuming.

The second point is that the personal maid service company, not to point out any particular company, chooses a two-and-one-half-hour minimum service period, so what's happening is that the client makes work for the housekeeper to do, especially if the visits occur more than once weekly. This is quite apt to happen as the one spouse gets much weaker and the care giver gets more and more tired. The solution has been to simply throw more housekeeping services at the care giver, so the care giver doesn't even do the dishes because, "A is coming tomorrow morning."

My recommendation is to replace this expensive one-on-one set of services with delivery routes. For example, laundry can be picked up and delivered. Grocery orders can be batched, selected, purchased and delivered to the client's kitchen counter. In fact, some grocery stores, for a minimum fee, will pick up elderly clients in a van and deliver the groceries home to the kitchen counter. Some stores will accept phone orders from regular customers and deliver the groceries and thus eliminate the need for housekeepers to shop.

Another example: A housekeeper perhaps could be assigned to an apartment building, to go from apartment to apartment to vacuum and dust weekly or once every 10 days. Nobody's place needs to be dusted every two or three days, in my opinion. For personal care services such as bathing, one person can spend a morning, yes, but with three clients; one hour each and up to one hour total billable time for walking between clients in a neighbourhood and one half-hour in an apartment building.

The benefits, as I see, from this type of thing is that the services can be more flexible in delivery. Instead of large blocks of time, the two-and-a-half-hour minimum, services can be delivered in half-hour or one-hour units. For example, clients may receive only personal care services for one hour weekly and not a two-and-one-half-hour block with a lot of unnecessary housekeeping. For example, a client may receive personal care twice daily—

morning and evening—for a period of one half-hour to one hour.

Expenses for the housekeeping services under this system I think would be drastically reduced by 50% or more. I don't think all the housekeeping services that are being given are necessary, and overall you would see enormous savings. Even better, the client is more independent and does not make work for the housekeepers.

For those clients with special needs, other arrangements such as what I call the personal maid delivery system may be cost-effective. However, for the vast majority of clients, streamlined delivery services should be sufficient. If the client wishes but does not require personal services, then the client should pay for them, not the taxpayer.

Secondly, I would propose that the savings that would be accrued from not delivering services one on one should be allocated to rehabilitation services to prolong independence. At the moment, clients receive housekeeping services weekly or more often, and the real health care from trained professionals is often ad hoc, with long periods of no professional visits at the client's home.

I observe that the client does not always receive follow-up professional rehabilitation services after respite care in an institutional setting. For example, my father suffered from cancer and from emphysema. He was put in the Elisabeth Bruyère Health Centre for one week in December 1992. They were able to put him on his feet and get him relatively mobile, and he went home and sat. It was unfortunate that there was no follow-up.

**Recommendation:** Use the savings from housekeeping services for perhaps biweekly visits by a trained therapist or other professionals to exercise, socialize and encourage the client to remain as independent as possible. These visits can be part of the follow-up from planned respite care days in an institutional setting.

**Benefit:** The client receives more services designed to promote independence. At the moment, the least qualified person in the whole system, the housekeeper, spends the most time with the senior who is ill and with the care giver.

Dovetail the mental health time for the care giver with delivery of rehabilitation services. The real problem is care giver burnout. My father was just short of his 81st birthday; my mother was 80. There really was burnout there. On duty around the clock, the care giver deals with the emergencies, the doctors' visits, therapies and psychological crises. The key to success of the home care, instead of costly institutionalization in long-term care, is the care giver, and respite care is essential.

Planning for respite care tends to centre around away-from-home care for the home care client. This is expensive and infrequent, too infrequent to maintain the health of the care giver. It's a short-term solution to a long-term problem. Like any short-term solution, it is helpful but often not enough in itself. When the care giver burns out or the care giver declines in health, the likelihood of institutionalization for both client and care giver adds up to big expenses.

At the moment, the theory is that the care giver may leave the home while the housekeeper is on the premises. However, housekeepers have no training or authorization to administer routine medically prescribed treatments such as oxygen or pills and other medications.

In one unfortunate scenario, a plug from a Ventolin machine was knocked out of the wall. My mother was away, the housekeeper was there and my father finally struggled to get the Ventolin machine plugged into the wall and we took him to emergency at 1 in the morning. This is the kind of scenario I would like to see something done about for other people.

1430

**Recommendation:** I would like to propose that you combine the biweekly visit by a trained professional with mental health time for the care giver. The care giver then may leave the home with the assurance that the client will get routine medical treatments.

**Benefits:** The care giver will be able to continue providing home care for longer periods of time with less likelihood of burnout. The quality of care by a refreshed care giver is higher than that of an exhausted one. The reduction in care giver burnout will promote long-term home care instead of the more costly institutionalization. Fewer care giver burnouts will mean reduced health care expense in the long term.

To summarize, I'd like to go back to the front page and tell you that I have proposed replacing the existing personal maid service with a new structure, a delivery route structure if you like. I would like to allocate these savings to rehabilitation services that would prolong independence, and I would like to dovetail mental health time for the care giver with delivery of these rehabilitation services.

**The benefits:** Services under this system can be more flexible in delivery. Instead of inflexible blocks of time, services can be delivered in half-hour or one-hour units. Expenses for the housekeeping services will be drastically reduced, by 50% or more. Even better, the client will be more independent and will not make work for the housekeepers.

When my mother moved in with me, she didn't think she should even wash a dish. I said: "Too bad. Here's a dishcloth, here's the dishpan, here we go." It took a while. What my mother needed was to be socialized, exercised, helped to do these sorts of things, and it has fallen upon myself essentially to do this since she's moved in with me. I do have help. I have a health problem which does not make it possible for me to help my mother bathe, so there is help coming in. There is also housekeeping help coming in because of these two-and-a-half-hour rules. The client receives more services, under the system I'm proposing, that are designed to promote independence. Fewer care giver burnouts will mean reduced health care expense in the long term.

I have no statistics to back this up. This is a personal opinion. I have not discussed these ideas with any care giving group in the community, any mental health group, any home care people. I've simply made my observations on what I've seen in my parents' home, in my own

home, in the neighbourhood as I walk around. As I say, based on these personal observations and my own work experience in observing and making recommendations, this is what I present for your consideration.

**Mr O'Connor:** Thank you for your presentation. One of the things we have heard over and over again is the need for the consumer to be involved in the process. In the case of Alzheimer's patients, it's important that the care giver advocate on behalf of the consumer in that type of situation.

We had a presentation this morning by Marianhill, and they do provide a terrific service for Alzheimer's patients through some day care programs. That type of program of course would be exempt from the 20% rule, and it's something we have discussed in this committee room before.

What you've raised here, it seems to me, would reflect the real need of the personal care and the plan of care, so the question I'd like to ask isn't of you but of the bureaucrats, if they don't mind, through the parliamentary assistant in reflecting what you've suggested here. I think you make good, practical suggestions. It's my hope that as the MSAs evolve we're going to have people like yourself giving those good, practical suggestions to the community group that's going to have a lead role within each community of the MSAs.

Would this be possible, the suggestions as raised here, Parliamentary Assistant?

**Mr Wessenger:** I'm going to ask Mr Quirt to comment, but it would seem to be that this type of flexibility which you advocate is what we ought to be building into the system of our MSAs. I'll ask Mr Quirt to indicate that.

**Mr Quirt:** If I might just comment on the three solutions you've offered, I think you've put your finger on one of the problems in the existing system in that when the home care program contracts with a number of different organizations, normally those organizations wish a minimum amount of time that they are going to be paid for before they're willing to go out and provide a particular service. Sometimes that's two and a half hours, sometimes it's four. Some agencies are more flexible, depending on the part of the province, and sometimes there are two homemakers from two different organizations on the same block.

You're quite right that this type of coordination, we hope, would be better achieved when service providers are the people who also decide who gets served, with how much service, when. That's one of the features of the multiservice agency, empowering the people who deliver the service to decide when and how much, rather than being dependent on the person who brokers or makes the arrangements with the client and then places orders with a number of different agencies.

Your second point is a good one, about the onsite services in apartment buildings. We hope through the redirection to almost double what's spent on supportive housing programs in the province, where people aging in place in apartment buildings receive onsite support services on a 24-hour basis so that if they have an

emergency in the evening, then someone can be there in a couple of minutes. It's not doctors or nurses but someone there to assist and to provide the degree of security they might otherwise have to get in a long-term care facility.

Your third point about care giver relief is a good one as well. While respite care isn't described in the bill as a particular, discrete service, we recognize that giving care givers a break is an important, legitimate reason for delivering service in the first place, whether that service is delivered by a volunteer, by a homemaker, by a nurse or a physiotherapist.

**The Chair:** Ms Margeson, you've brought forward a number of points which I think, as you can see, the committee has found most interesting. We thank you for taking the time and coming down here this afternoon.

OTTAWA-CARLETON REGIONAL  
DISTRICT HEALTH COUNCIL

**The Chair:** I call on the representatives from the Ottawa-Carleton Regional District Health Council. We welcome you all to the committee.

**Mrs Jacqueline Neatby:** My name is Jacqueline Neatby. I chair the long-term care committee of the Ottawa-Carleton Regional District Health Council. I feel privileged to be able to speak to you this afternoon on behalf of this committee and the Ottawa Carleton district health council, a council which as you know has over 20 years' experience in planning long-term care services.

I am accompanied by Mrs Avril Gunter, who chairs a working group of 33 members to implement the government's MSA policy. Mrs Gunter, two years ago, co-chaired the community consultation on long-term care, so she's well able to take this task in hand. We also have Mr Cal Martell, our able long-term care planner, who is a member of council staff.

As we have submitted a written brief, my comments will focus mostly on key issues which we would like you to consider. Before doing so, I would like to describe the context in which we are undertaking our long-term care reform.

Unlike many areas in the province, community-based services in Ottawa-Carleton absorb more than half the total provincial subsidy for long-term care services; that is, 59%. In 1991 the total provincial subsidy was \$120 million. Of this, \$66 million, 59%, was directed to 40 agencies which provide services which the government has earmarked to fall under the MSA. It is important to note that 94% of this \$66 million goes to four agencies, the largest proportion being home care. This means that the remaining 6% goes to 36 agencies, largely voluntary community-support services agencies.

1440

These agencies deliver an impressive array of services with small staffs and over 3,400 volunteers. They could not do so with provincial funding alone. Hence, they supplement it with municipal funding, United Way funds and voluntary fund-raising.

The strength of our voluntary sector and the existence of an impressive network of services has influenced our approach to the government's MSA strategy. As you've

been told before this afternoon, we want to build on the strength of existing services, so our approach has been to work from the ground up; that is, to achieve the goals of the reform by concentrating on the functions of the MSA rather than by beginning with a predetermined form or structure.

I want to make clear that we haven't committed ourselves to any structure yet. This will happen through a community process. The 33 members of Mrs Gunter's committee represent all stakeholders, all sectors of the community, and it will be a community consultation process taking it a step at a time.

Just now we are working on the most vital function of the MSA; that is, simplified access to services. This includes a proposal for a regional telephone information and referral service. It will be submitted to the community for consultation this fall. By the fall of 1995, we expect to have recommendations dealing with the other functions of the MSA, namely assessment, coordination and structure.

We are undertaking this work with energy and commitment, because although we have a rich network of services, we need to organize them into an integrated system and we need to fill important gaps such as services to the physically disabled and services in rural areas.

We support the goals of the reform and we applaud the government for propelling this much-needed reform. However, our study of Bill 173 leads us to fear that the legal tools and mechanisms therein will subvert the goals that we are striving to attain.

Above all, we're seriously concerned about the consequences of section 13, which limits by category the ability of MSAs to purchase services from service providers. The intent of this section is to force the amalgamation of existing agencies because the government believes that the integration of case management and service delivery is the way to ensure access. There is no definitive evidence that this is the most appropriate way to achieve access.

Moreover, we believe there are significant consequences to the amalgamation of agencies. The ensuing loss of the autonomy and the identity of many of these grass-roots organizations may lead to the erosion of their community development functions as against their service delivery functions, functions currently assumed by volunteers as well. As these functions become increasingly discharged by MSA staffs, volunteer involvement will weaken, and no amount of resourcing can make up such losses. As a volunteer once said, volunteers do not grow on trees. Therefore we recommend that communities be given greater flexibility in their choice of options to achieve an integrated long-term care system, a choice greater than that provided through overreliance on agency amalgamation.

Again, section 13, in limiting the purchase of service by category instead of globally, seriously limits the capacity of a community to maintain agency partnerships which require an approach which is different from the home care model proposed throughout the act. Examples of services which require a different approach are elderly

persons' centres, certain home support programs and adult day programs, which are wellness-oriented rather than needs-based. Therefore we recommend that the limitation of purchase of service be done on a global rather than a sectoral basis. In the event the government remains committed to the limitation, this would enable communities to maintain at least some of the existing agency partnerships appropriate to those they serve.

Now let us look at part VII and part VIII. These two sections which outline the duties and obligations of service providers reflect many guidelines in place for the home care programs. Again, this bill does not distinguish between an approach which is appropriate for illness and related services and one which is appropriate for wellness and health promotion. Therefore we recommend that the extension of rules governing approved agencies, part VII, and service providers, part VIII, be reconsidered because they are not appropriate for the informal, grass-roots nature of certain programs with a wellness, consumer-driven and peer support orientation.

On the subject of appeals, we were surprised by the rules governing appeals at sections 32 to 40. If the MSA is to be a community agency, it is puzzling that its clients would be given a right of appeal to a provincial body with respect to decisions about the content of service plans, the level of service and the termination of service. How will agencies be able to establish priorities if their decisions are rescinded by a provincial appeal board, especially in the face of increased demand for services—the government's policy certainly leads to that kind of expectation—and increasingly limited resources? Therefore we recommend that appeals to the health services board apply to provincial policy only and not to local service delivery decisions.

Now, about service plans, I would like to call attention to section 20, which requires everyone to be assessed and have a formal service plan. This seems to jeopardize the very independence of the consumer that the reform wants to promote. Again, this section applies to the case management practices of the home care program. We do not think this approach is suitable for social, recreational and home support services which focus on wellness. It is indeed hard to imagine how someone might be assessed as needing to attend a bridge club in an elderly persons' centre. This bureaucratic approach will indeed discourage persons from taking advantage of these services, thereby discouraging the initiatives consumers might take to maintain their independence.

We think that the issue of personal records is important. Therefore we strongly support the provisions of section 29 which ensure a client's access to their personal record. This will indeed relieve the frustrations that consumers have endured.

French language services: In her public statements, the Minister of Health has made a very strong commitment to the provision of services in French in designated areas, yet there is no direct reference to French language services in Bill 173. It does not suffice to say that the French Language Services Act of 1986 will be operative. This act would not legally oblige an MSA to provide services in French in a designated area. The act only

obliges government ministries, agencies, boards and commissions, whose directors are all appointed, or a majority thereof, by the Lieutenant Governor In Council.

An MSA, like any other transfer payment agency or any voluntary agency, would have to apply voluntarily for designation and undertake to meet the requirements of designation. We know from experience that this is not a satisfactory way of ensuring the establishment of a range of services in French comparable to those offered in English, as would be necessary in this community, for example. We therefore recommend that Bill 173 contain a provision stating that in areas designated under the French Language Services Act, appropriate MSAs will be designated as agencies falling under the act.

#### 1450

District health councils: We appreciate the clarification of the role of district health councils contained in Bill 173. We notice, however, that there is no specific reference to the responsibility of district health councils for the setting of service priorities. This is an essential requirement for long-range planning and the proper allocation of funds. We therefore recommend that Bill 173 specify that the responsibilities of the district health councils include the setting of local priorities.

Social services: We are greatly concerned that the cumulative effect of Bill 173 will result in the assimilation of social services rather than their integration with health services. Our written brief describes several aspects of the bill which will have that effect. This means that social services which help maintain individual wellbeing and independence will be downgraded and eroded. We invite you to examine closely the many ways in which this bill subverts an important goal of the reform.

I would like Mrs Gunter to recapitulate the main recommendations contained in our brief, if that's all right with you, Mr Chairman.

**The Chair:** I always get concerned about allowing time for questions. If it's simply reiterating them—by all means, it's your time, but I was going to try to allow each caucus to ask some questions.

**Mrs Avril Gunter:** We therefore recommend:

—With reference to section 13.2, that communities be given greater flexibility in their choice of options to achieve integrated long-term care systems than is provided for through overreliance on agency amalgamation.

—That the limitation of purchase of services be done on a global rather than a sectoral basis. This will enable communities to maintain at least some of the existing agency partnerships appropriate to those they serve.

—That the extension of rules governing approved agencies, part VII, and service providers, part VIII, to all services be reconsidered, because they are not appropriate to the informal, grass-roots nature of certain programs with a wellness and consumer, peer support orientation.

—That section 32 be amended to provide for appeals to the Health Service Review Board with respect to provincial policy only and not local service delivery decisions.

—That Bill 173 include specific provisions to ensure

the appropriate designation of MSAs in areas designated by the French Language Services Act.

—That the responsibilities of district health councils specifically include the setting of local priorities.

**The Chair:** With the committee's indulgence, because we have before us the district health council which has been charged with the planning for long-term care, I'm going to allow each caucus a question. I would just ask if members could keep in mind the time and keep their questions sharp and short and succinct. That way we can move through quickly.

**Mrs O'Neill:** Thank you so much for coming. The thing that hit me as unique about your presentation was when you said "community development" and how closely related that is to the volunteers and what that really means in this community. You've brought forward the appeals process, as this community only can talk about the French-language services and the instability, and we've had that presentation.

I wanted you to go back to your last general concern. You talked about the increased flexibility, communities being given greater flexibility. Would you be able to focus on the three areas—you want to put four, but I'm asking for three areas—where you think flexibility would really improve this bill?

**Mrs Neatby:** This flexibility of course refers to the structure and the manner of coordination. I would like Mrs Gunter to address this because this is within her MSA mandate.

**Mrs Gunter:** You're talking about the global rather than the sectoral?

**Mrs Neatby:** Yes.

**Mrs Gunter:** The thing is that we have heard that 94% of the transfer agency money is spent by four agencies. That leaves only 6%, which is spent almost entirely in the home support area. If the 20% designation was allowed to be done on a global basis, this would enable many of the services now provided on a neighbourhood basis by many volunteers who are dedicated to their own particular areas, specialized services like respite care services and day programs to come in that 20% sector. There is no way, I think, that we could duplicate the complexity of the services we presently have if we had to offer them all through separate MSAs.

**Mrs Neatby:** You must remember that some of these community support services are delivered by a great variety of agencies. They're embedded in the structure of some multifunctional agencies. Just to give you an example, Glebe Centre, in our area, has 195 residential long-term care beds, it has a social recreational centre, but it has grafted on to this community support in the neighbourhood. All this enables shared resources of Glebe Centre to be used to provide that multifunctional, and it is to dismantle some of these long-established created services that I think would be not only expensive but would lead to a loss of service.

**Mrs O'Neill:** Partnership with the facilities.

**Mrs Neatby:** Yes, this is what I mean by the partnership.

**Mr Jim Wilson:** You make a number of very good

suggestions, many of which, in fact almost all of which, I and my caucus colleagues agree with. We'll be introducing amendments to, for example, get rid of the 80-20 rule, for which there seems to be no justification from the government, amendments to get rid of a number of things. However, having been Health critic for almost four years, I can tell you that when bills leave this committee process they essentially look the same way they did when they entered this committee process, so I need some help from you.

We are very concerned with the monopolistic nature of MSAs in terms of their dual role of not only being one-stop access but also the twist that seems to have appeared along the way on the road to reform that they'll also have a monopoly in delivery of 80% of the services. Had you proposed, along the way, a different model? My question specifically is, is it necessary to amalgamate and destroy, in fact, some of these community agencies like the VON in order to achieve the objectives and principles that the bill speaks to?

**Mrs Gunter:** I think we need much more coordination between agencies. In the past this has been lacking, and we have been working very hard and with considerable success in this area, in getting cooperation and coordination between agencies. But though we wish to have more coordination, we do not feel this means that the agencies have to completely disappear, although they may be reformed in a slightly different way.

**Mr Jim Wilson:** The level of cooperation towards that goal in this region is high right now. If the government backed off for a while, would you be able to achieve that point of access, the regional phone number that was talked about, that sort of thing, without this legislation, or do you need this legislation as a gun to someone's head to get them to come to some new governance models? It's a very blunt question, but I'm a fairly blunt person.

1500

**Ms Neatby:** We had been encouraged by some of the government's proposals for transitional strategies, and there seems to be a backing away from this. We had been encouraged because in our process, as I said, we start from the ground up, with the whole community there, and work out the first, say, access and then see through that process how we—and of course we measure the costs as we go because we assume that we are not in this community. We don't assume additional funding because, for reasons of equity, and we agree with this, there are areas that are less well provided, so we'll have to make do with what we have. Hence the costs, as we go along, are significant because we don't want to increase bureaucratic structures and reduce services.

This is why our process, in terms of the interim strategies, seems to justify and encourage the way we've been approaching it and which suits us in this community. But we don't know if the government really means to back away from these interim strategies or not. The bill doesn't seem to give much encouragement there.

**Mr O'Connor:** One of the areas you touched on were the services that would be provided within the community, the needs the consumers have. When the needs of the

consumers are assessed and plans of care developed, then they would hopefully fit somewhere within what's been described as a basket of services, though I think you touched on an important element, which is the need for the local area to be involved in the planning of the services to be provided.

I got from what you presented, though, a sense that you felt somewhat constrained by what you would need to plan and provide for. I just wondered how that might reflect what would be the needs as laid out when the assessments of the individual needs have been done through the plan for care.

**Mrs Gunter:** I'm not quite sure of the intent of your question. We have been looking at what we want our long-term care system to do. We have looked at the things that are working right now. We have looked at the things that need to be changed, many of which came out of the long-term care consultation process, and we are trying to change the system so that it will meet many of the needs that people expressed.

We are starting this at the beginning with the information referral part of the package because that essentially was the one that people had most problems with. We are at the same time working on service coordination between agencies, trying to standardize the intake and assessment part of the picture.

We are looking at then moving into the assessment part of the process. We await with great interest the assessment package the province is in the process of developing, which we hope will be one you can put into place in stages, so that if a person only needs a minor assessment because they are just looking at recreational services that could be done, that person in the recreational stage wouldn't have to go through a total assessment and so on. We are proceeding in stages, and we have hopes that things are going well. We will be having extensive community consultations this fall on a number of the issues.

**Mr O'Connor:** I'd certainly encourage the consultation. You've pointed to a lot of good things that can come about by having such an extensive consultation.

**The Chair:** I know we could spend quite productively the rest of the afternoon. I'm afraid that if we did we wouldn't get through all the other presenters. May I, on behalf of the committee, thank all of you for coming today.

#### COUNCIL ON AGING FOR OTTAWA-CARLETON

**The Chair:** I call the Council on Aging for Ottawa-Carleton.

**Mrs Sylvia Goldblatt:** It's a pleasure to be here. I'm Sylvia Goldblatt, the current president of the Council on Aging for Ottawa-Carleton. With me is Jean Shaw, a fellow volunteer, who has chaired the long-term care task force that looked at Bill 173 and produced the document that you have in front of you.

As usual, the document is far too long to present the whole thing, so what you're going to get from me is an abridged version. I hope we've cut out enough so that we leave time for you to ask questions, because your questions have been so helpful.

The Council on Aging for Ottawa-Carleton is a non-profit planning, coordinating and advocacy organization which has just launched its 19th year serving the 70,000 residents of the region of Ottawa-Carleton who are 65 years of age and over. The council is composed of seniors, professionals delivering services to seniors, care givers and others interested in seniors' issues. One of the fundamental roles of the council is to study issues and advocate on behalf of the senior consumer when appropriate.

As president of the council on aging, my comments will focus on the implications of Bill 173 from the perspective of older consumers and their care givers. I just want to throw out how pleased I was to be here for the earlier presentations, because I could see that we're all coming to you with a great many similar points. It's almost a good thing that you're going to be a little bit bored with it, but at least you're going to hear it over and over again.

It's apparent from Bill 173 that the government has continued its commitment to the development of a system which will provide services to consumers to meet their changing needs within the context of a continuum of care. It has been well documented that over 80%, actually as much as 95%, of care giving is provided by family, friends and neighbours. It will be important to continue the emphasis on consumers, care givers and volunteers to ensure that the multiservice agencies will reflect this orientation in the way it is structured and the cultural philosophy it adopts.

The council on aging also commends the government for its initiatives designed to provide safeguards for consumers, in particular the establishment of a bill of rights.

Due to the far-reaching implications of the regulations for Bill 173, the council on aging requests that there be further consultation with communities once the regulations are prepared. That will really be very important to us.

Mr Chairman and committee members, our brief will specifically deal with a number of issues. You have a list of them in front of you. I'll identify them as I go through them.

The first one we're dealing with is respite care. I just want to throw in that yesterday I spent the day in Montreal at a respite care conference, I guess really workshop, where this issue was dealt with in great detail, and it is obviously considered a very important one.

#### 1510

The council on aging was encouraged to see the inclusion of care giver support services and adult day programs in the mandatory services to be provided by or ensured by the MSA. However, we want to draw attention to the need for a commitment to availability of services 24 hours a day, seven days a week. As we all know, things don't stop at 5 o'clock on Friday and start again at 9 o'clock on Monday morning.

Bill 173 defines care giver support services in clause 2(1)(e) using the word "respite" on only one occasion. In addition, only care giver support services and not respite

per se are identified as mandatory services in subsection 2(4). It is not clear from this terminology whether direct care giver relief programs such as in-home respite services are considered essential and will be provided. That case was made very well by the individual who spoke with you earlier.

We want to emphasize that relief for the care giver is critical for several reasons. It is key to sustaining the care recipient in the community. Without that care giver, that recipient might very well be in an institution. It can help to avoid health problems for the care givers. And it could be a deterrent to elder abuse, a subject we're all becoming increasingly sensitive to. It should be noted that homemaking services, personal support and professional services are directed towards the care recipient and that the provision of these services should be recognized as distinct from the needs of the care giver.

We're making a series of recommendations. I'm going to deal with the second one—the first is certainly included in our recommendations but this is one that I'm going to address—where we're recommending that respite care for the care giver be either incorporated into the care plan for the consumer receiving services from the MSA or be considered within the context of the care giver as a consumer in his or her own right. It is recommended, secondly, that in-home respite programs be provided as a mandatory service by the MSA and available for that 24 hours a day, seven days a week.

The second issue that we're addressing is consent. With the increasing emphasis on care being provided outside of institutions, inevitably more demands will be placed on care givers. In the development of service plans, if those responsible view the care recipient and the care giver as a unit requiring support, then services such as respite care will be promoted as part of the care plan. However, if the care recipient refuses to cooperate with the service plan but the care giver requests the service, it is uncertain how the care giver's request will be viewed. The council is concerned that expectations placed on care givers by the care recipient may at times be unrealistic.

We're recommending that Bill 173 include a statement concerning the rights of the care giver in addition to those of the care recipient, and secondly, that the government examine the issue of consent for services within the context of conflicting needs between the rights of the care giver and the care recipient.

The next issue I'm addressing is volunteerism. Existing services in the long-term care sector have depended greatly on volunteers. You've heard that from a great number of people today. We have somewhere around 250 volunteers working with the council on aging. With the current climate of fiscal constraint on government resources and funds, the participation of volunteers will be required even more in the years ahead.

We're recommending that Bill 173 should include a clause that every effort will be made to maintain the present level of volunteer service and to increase volunteer participation where appropriate.

Our next issue is recreation and social programs. The need to support wellness through the provision of health promotion, illness prevention, rehabilitation and social

support programs has been emphasized by both consumers and provider organizations. The council on aging is concerned that the focus of Bill 173 now appears to be primarily on preventing institutionalization, with inadequate attention being paid to health promotion and illness prevention strategies. The council notes the inclusion of recreational and social programs as a recent addition to the services that will be offered by the MSA. However, it's not clear in the legislation how these programs relate to wellness and health promotion or what the impact will be on elderly persons' centres, which we've always seen as a critical service.

We're recommending that the government clarify the types of social and recreational services that will be covered by the legislation and available through the MSAs. We're also recommending that the government demonstrate the way in which Bill 173 reflects the importance of wellness programs through the provision of services by the MSA. We're further recommending that the government clarify the potential impact that this change will have on elderly persons' centres.

I'm flipping pages.

Under consumer fees, I'm just going to read our recommendation there. It's recommended that the government clarify which services will require payment by consumers and the method by which consumer payment will be calculated.

Our next issue is a limit on purchased services, and I know this one has been addressed by several other organizations. Bill 173 provides a restriction that not more than 20% of the amount budgeted for the four MSA service areas be used for the purchase of services from other service providers outside the MSA. We believe this will result in less flexibility in the design of the MSA in areas such as Ottawa-Carleton. The council is concerned that adherence to this provision may result in considerable disruption in services to the senior consumer.

We're recommending that the government provide increased flexibility in the percentage of services to be contracted out by the MSA. This percentage should be responsive to the realities in local communities and be determined through the planning process at the district health councils.

Our next issue has to do with physician involvement. I'm interested that we haven't heard about this earlier this afternoon; maybe you did this morning. The movement from a system where physicians have typically been the gatekeeper for many services to one in which they appear to be relatively excluded from the process is troubling. Well-defined relationships between physicians and the MSA need to be established in order to ensure that a true continuum of care can be realized. The council supports a model that envisions a holistic perspective in the care of the elderly.

Our recommendation is that the important role of the physician be recognized and that physicians be part of the process when the government is determining the structure and functioning of the MSA. We're further recommending that the relationship between physicians and the MSA be well defined and incorporated into the regulations for the MSA.

**1520**

We want to reiterate here our next issue, the French-language services. The council on aging supports the development of services which take into account linguistic requirements. Specifically, areas which are designated under the French Language Services Act must develop services to meet the needs of francophone clients. We're recommending that the government revise Bill 173 to incorporate the stipulation that services must be provided in French in designated areas under the French Language Services Act.

Our next issues deals with governance. Here I want to simply identify our recommendations. We're recommending under governance that specific statutory recognition of volunteers, seniors and care givers be accorded in the composition of boards of directors of MSAs. We're also recommending that the requirement for approval of approved agencies and designation of MSAs be statutorily established. It's recommended that protection from liability be extended to include approved agencies, including MSAs, their directors, officers, employees and volunteers. We further recommend that any application for temporary or permanent status of an MSA include the method used to determine the board membership.

The summary and conclusion: The council on aging supports the policy direction set out in Bill 173, which provides safeguards for consumers and emphasizes the importance of consumers and their family care givers as the focus in the long-term care reform. The council does however feel that clarification is required regarding the level of support that will be provided to care givers, in particular for respite care, and how this will be determined in relation to the consumer service plan. With the policy direction of providing care increasingly in the community, adequate support for family care givers is crucial.

The council also feels that clarification is required that describes the types of social and recreational programs to be delivered through the MSA. The relationship of the MSA to elderly persons' centres should also be spelled out. The emphasis on health promotion and illness prevention must be supportive and reflected in the legislation.

The council recommends that the government revise its policy on the limit of purchased services in order to give increased flexibility to communities to design a system that best meets their needs. Through the district health council planning process, communities would then be able to establish services with the least disruption to the consumer.

The council has consistently raised concern regarding the lack of mention of physicians within the context of the long-term care reform. Relationships and linkages must be established and set out in the regulations between physicians and the MSA so that the espoused continuum of care becomes a reality.

And finally, the important role of volunteers needs to be reflected in government policy. Specific statutory recognition of volunteers, seniors and their care givers needs to be included in the boards of directors of MSAs. Furthermore, it is recommended that protection from

liability be extended to include approved agencies, including MSAs, their directors, officers, employees and volunteers.

The council on aging appreciates having had the opportunity to comment on the draft legislation in Bill 173 and hopes the government will continue its commitment to community consultation. Due to the far-reaching implications of regulations for Bill 173, the council on aging recommends that the government accord communities another opportunity to provide input when the draft regulations are prepared.

**The Chair:** Thank you very much for a very full presentation. Every now and then the Chair has to be the heavy and look at the watch and see how we're doing with groups, so I'm afraid I'm only going to be able to allow one question at this time. It's my fault, not the committee's. Mrs Sullivan.

**Mrs Sullivan:** I appreciate this presentation. In your presentation you've underlined what at least two other organizations have done today and others have done on occasion, and that's to emphasize the role of the care giver.

I think the point you make about the conflict between the consent of the care giver and the care recipient is an important one, because what we see is an assessment of eligibility which may in fact be determined by whether there is a care giver in the home, whether or not the care giver feels that he or she is able to provide the care at the level that the assessment may indicate. I don't know how we're going to deal with that, but I think it's a matter that certainly has to be taken into account. As I think about it, I don't think the consent to treatment laws, when they come in, will deal with that issue. There may have to be something included in the regulations with respect to what happens when a care giver says, "No, I cannot do that."

I'm also interested in the question of physician involvement which you've raised. I think that in the assessment process we've heard a number of issues, one of them with respect to risk identification, which wouldn't require a full assessment. The other thing that we have heard is that about 90% of the cases that are in-home care do have a clinical component, and we don't see any reference to either physicians or in fact other practitioners who would deal with that clinical aspect of care. Certainly, if we're dealing with a full continuum, that has to be taken into account.

We've heard suggestions that, first of all, the family physician should be involved in the assessment process. For many that's the appropriate thing, but for others there is no family physician.

We've also heard that the MSA should be required to have a medical director who is on staff as a consultant. I just wondered if you would comment on any value that you would see in a medical director and how you think MSAs ought to be able to integrate that clinical need into the assessment process.

**Mrs Goldblatt:** I certainly see that as a useful option, that a clinical director, medical director, be included in the MSA. The thing that I'd also, though, be prepared to

see—the district health council has, as you know, traditionally dealt with doctors and hospitals and so on. I think they should be in a pretty good position to come forward with a constructive recommendation as to how we get this physician involvement into the MSA.

**Mrs Sullivan:** I guess my concern is that there's not only difficulty with the physician relationship with the MSA, but there is also a difficulty with the institution and facility relationship with the MSA, the hospital or the nursing home or whatever, if you're moving in an appropriate continuum.

**Mrs Jean Shaw:** If I could just say a few words to that too, I think we have to remember when we're talking of seniors that the ones who are requiring the care in the home are usually very elderly. We're talking of people in their 70s and 80s and 90s, and the supports that they have known all their life are gradually falling away as their friends and family die. So these people have very few familiar faces around them, and a trusted family physician has a great support value for elderly clients in their homes. I think, as far as the MSA is concerned, there certainly should be family physicians represented on the board itself because they have a very unique relationship with the client which is apart from anything in an institution.

1530

#### COUNTY OF RENFREW

**The Chair:** I call upon the county of Renfrew representatives to come forward. Gentlemen, welcome to the committee this afternoon.

**Mr Alvin Stone:** My name is Alvin Stone and I'm warden of Renfrew county. I'm pleased and I want to express our appreciation to yourself and the committee members for affording us the opportunity to present our submission on Bill 173. I believe that our brief is similar to a lot that you've heard today, and it's comforting for us to know that for the most part, Ontarians are singing from the same hymn sheet.

With me today is Michael Johnson, the chief administrative officer and treasurer of Renfrew county. Mike's available to answer any questions following the presentation of our brief. Also with me is Andrew Dickson. Andrew is a member of our welfare and homes for the aged management committee, which is a sister with the city of Pembroke. I'd ask at this time if Reeve Andrew Dickson would present our submission to the standing committee on social development.

**Mr Andrew Dickson:** Our delegation represents the council of the corporation of the county of Renfrew. The county of Renfrew extends from Arnprior, west of Ottawa, along the Ottawa River to Deux Rivières just east of Mattawa, with its southwesterly boundary being at Combermere, north of Bancroft. The county is the largest geographic county in the province of Ontario, comprising some 7,793 square kilometres with a population, excluding the city of Pembroke, of approximately 75,000.

The county of Renfrew does not directly deliver home care services, but we do have a long association with the delivery of those services through the Renfrew County and District Health Unit, which our organization partially

funds. We appoint four county councillors to the board of health of the Renfrew County and District Health Unit. The Renfrew County and District Health Unit is the entity directly responsible for the delivery of home care services in our county and has, we believe, an excellent and enviable record of providing quality, cost-effective home care services.

Accordingly, while we have no direct involvement in those areas respecting Bill 173, An Act respecting Long-Term Care, we do have a very obvious and intense indirect interest in the future of long-term care home care services in our county.

We also, by way of introduction in this brief, note the representativeness of our organization and thus the accountability of our organization to the people of Renfrew county. In the last municipal election, November 1991, approximately 50,000 of our total population of 75,000 cast ballots. We believe that this fundamental accountability of our elected people for services delivered by municipal government, or by boards or commissions on which municipal government has elected representation, constitutes the highest form of accountability in our democratic system. We will return to this theme later on in this brief.

We also want to be on record early in this brief by noting that we support what we believe are the government's intentions with respect to those matters set out under Bill 173. We support the government, if it is their intention under improvement to home care services, to establish a system that provides more responsive services, more efficient services, more accountable services and more rationalized services. These are clearly desirable and indeed "motherhood" goals to which all of us at every level of government would subscribe.

Having stated our support for these principles, we are compelled to note that our experience in long-term care reform, as reflected in Bill 101, the Long-Term Care Statute Law Amendment Act, 1993, does not provide confidence in the viability of the government's long-term care reform planning process. While we all recognize the plight we are in, in these economic times, of reduced governmental revenue and far too great a portion of expenditure is being required to service the federal and provincial debt, the fact remains that we have moved, on the institutional side of long-term care, to fewer beds, less funding in real dollars, less resident care, more provincial rigidity, more provincial control, more provincial centralization and less capacity for local innovation.

At a time when the demographic projections of the increase of elderly are little short of awesome, with 25% of the population of our county expected to be age 65 and over within the next 25 years, we have experienced provincial government intervention in the operation of municipal homes for the aged to such an extent that fundamental questions are being asked at the municipal level with respect to the appropriateness of the delivery of long-term institutional care as a municipal responsibility.

At the municipal level, the financial uncertainty created under Bill 101 virtually prohibits any intelligent financial long-term planning. Our county, in cooperation with the

city of Pembroke, operates a 180-bed long-term care institution in the town of Renfrew and a 166-bed long-term care institution in the city of Pembroke. The provisions of Bill 101 are such that we are unable to obtain any true commitment of financial partnership from the provincial government in terms of guaranteed present funding, even without recognition of inflation, beyond 1994 and no guarantee of provincial partnership when our organization is faced with costs beyond our control, as best indicated by a recent binding arbitration award under one of our collective bargaining agreements. This particular arbitration will result in an additional cost to our organization of approximately \$600,000 incurred in 1994 for the years 1993 and 1994. As we sit before you today, there is absolutely no assurance from the provincial government that under the provisions of Bill 101 they will cost-share in these uncontrollable expenditures which we have incurred.

The consultation process: We recognize that the province submits that it went through an extensive consultation process prior to the tabling of Bill 173. Having been a participant in and an observer of that consultation process, we are compelled to state to this standing committee our respectful opinion that the process fell far short of its intended goals of receiving a true cross-section of input from service consumer, service provider, the tax bill payer and the general public across this province.

Certainly, from our observation of the consultation process, one could be forgiven for wondering to what extent there was an agenda for the eventual provisions of Bill 173 before the consultation process even commenced. Otherwise, where did some of those principles enshrined in Bill 173 come from?

It is our observation that some of the more problematic provisions—

#### *Interjections.*

**The Chair:** Order, committee members. It is the middle of the afternoon. I know we have all been sitting here very patiently, but we are here to listen to the delegation, so I would ask everyone if perhaps they might keep their thoughts to themselves as we go forward. Thank you.

Please go ahead.

**Mr Dickson:** It's our observation that some of the more problematic provisions of Bill 173 were not promoted in any credible way throughout the consultation process, flawed though that process may have been.

Surely it is essential, in these financially restricted times, that one be careful not to destroy that which has been carefully constructed over a long period of years in any impatient crusade to construct a new system. The existing home care services have evolved over a very long period of time through the efforts of a large number of highly intelligent people, highly competent organizations and highly motivated volunteers. We submit that the principle underlying any revision of home care services should be to build on the solid foundation already in place rather than to dismantle the structure presently in place in the name of some theoretical

improvement. Why, in heaven's name, would one throw the baby out with the bathwater?

The accountability aspect: We turn now to the very significant issue of accountability under Bill 173, and especially with respect to the multiservice agencies proposed by Bill 173. The words "accountability," "community-driven" and "bottom up" have become buzzwords to which it is politically correct to subscribe. Unfortunately, in the application of those buzzwords, one too frequently finds a lack of reflection of reality. All too often, the implementation of those buzzwords more accurately seems to reflect either woolly headed thinking or pure wishful thinking.

The establishment of a brand-new bureaucratic structure, to be called a multiservice agency, with a board of directors to be appointed in some type of elite manner and with the buzzwords of "accountability," "community-driven" and "bottom up" to be satisfied in some form of sparsely attended annual meeting typical of so many other so-called accountable community-driven organizations is hardly a credible example of true accountability.

#### **1540**

We respectfully submit that the only true accountability in a democracy is at the ballot box. It follows, then, that the truly accountable organizations in the province are those, such as municipal government, that are answerable on a triennial basis at the ballot box, who are responsible for the money they raise from their tax base and who are responsible for the actions of their appointees to boards and commissions that deliver publicly funded services.

Perhaps the single most troublesome aspect of the proposed establishment of multiservice agencies is that they would represent a monopoly. We are compelled, therefore, to ask a fundamental question: What makes anyone believe that this newly created monopoly will work effectively? Monopolies get bigger bureaucratically; monopolies get less responsible; monopolies get less efficient; monopolies get more autocratic; monopolies get less innovative; and finally and importantly, monopolies discourage volunteerism. Where are the monopolies that are efficient and responsive, and getting more so with the passing years? We strongly submit that they do they opposite.

The theory that efficiency, effectiveness, responsiveness and accountability will be found in a centralized agency responsible for all home care service planning and management and all long-term care service delivery stands neither the test of experience in other jurisdictions nor the test of modern management principles.

Loss of volunteerism: In an area where volunteerism forms a fundamental underlining of our social structure and culture, we are deeply troubled by the impact of the proposed multiservice agencies on volunteerism in long-term care. We note that the Ministry of Health also recognized the public concern with this aspect of multiservice agencies and has responded by producing, on a frequent basis, a propaganda sheet called Long Term Care Action Facts. The purpose of this publication from the Ministry of Health appears to be to attempt to allay fears across this province that volunteerism will be negatively affected by the creation of multiservice

agencies. Obviously, this argument is falling on sceptical ears.

The second purpose of the publication appears to be to convince readers that multiservice agencies represent true accountability. We have addressed the matter of accountability earlier in this brief and will simply note that the Long Term Care Action Facts is as short on credibility with respect to the issue of accountability as it is with respect to the issue of volunteerism.

We refer you to the brief from the Catholic Health Association of Ontario. With respect to volunteerism, they said: "The passionate commitment of our staff and volunteers to the philosophies and values of these health care organizations are not the product of a 'service name logo or a service location.' They are the product of our heritage." They go on to say: "How do you transplant the 'heart' of an organization into a bureaucracy? It cannot be done." We hope that this committee, and through it the government, was listening to those sentiments, as expressed by that organization. We go on record as strongly supporting their position.

Approved agencies and other service providers: Section 13 of Bill 173 provides that the multiservice agency shall not spend more than 20% of the amount budgeted for community support services, homemaking services, personal support services or professional services in the agency's approved budget for the purchase of services from other service providers. This arbitrary number, previously set at 10%, totally limits local innovative approaches to the purchase and delivery of services. One is compelled to inquire, what is magic about 20% now when 10% was magic before? Surely, the guiding principle should not be some rigid mathematical percentage limitation but rather the ability of local communities to best design the coordination and delivery structure which would work most effectively in that community.

Inherent in the 20% limitation under section 13 is the bill's intent to squeeze out both existing for-profit and not-for-profit program delivery organizations. The not-so-subtle bias of the government objecting to for-profit organizations is eminently displayed in this bill. Our organization is compelled to ask, what is so fundamentally unacceptable about for-profit organizations? Why the bias? Why the flagrant determination to squeeze them out of the home care service delivery system when the track record of so many organizations is unchallengeable?

Our county, through our economic development department, spends hundreds of thousands of dollars a year attempting to promote and attract private enterprise and its job creation attributes to our county. Here on the one hand we have the county of Renfrew attempting to assist growth in its existing local industries and attempting to attract new industries to our county for job creation and economic growth purposes, while the provincial government deliberately sets out to destroy efficient and effective for-profit health care deliverers already in existence.

Equally problematic is the impact that the provisions of section 13 of Bill 173 would have on such historic and highly reputable not-for-profit volunteer organizations such as the Canadian Red Cross Society and the Victor-

ian Order of Nurses, to name only a couple of the most obvious. It is our respectful submission that the track record of organizations such as these is such that the provisions of Bill 173, the implementation of which would inevitably result in a major squeezing of their ability to be viable, possibly to the point of their having to suspend operations in many parts of the province, is simply and utterly unacceptable.

Instead of the creation of a new and all-powerful multiservice agency as envisioned under Bill 173, we pose the question, what is wrong with choice? What is wrong with the competition that comes from providing choice? Our organization rejects the philosophy that the needs of long-term care recipients will be better served by eliminating choice from the program services menu.

Costs: We also want to go on record today as supporting those organizations that have appeared before this standing committee and made the prediction that Bill 173 will not provide better services, but what Bill 173 will do is cost more. With respect, we want to say to the standing committee that if this government persists in enacting Bill 173 in its present form, we can only hope that as an organization we have the opportunity to revisit the credibility of Bill 173 at some future meeting of this standing committee on social development, in a few years' time, to review the cost results of the enactment of the bill. We predict that the cost results will certainly not be a pretty picture.

In conclusion, the county of Renfrew notes and supports the thoughtful and well-researched positions of a number of organizations which have presented this standing committee with excellent briefs. Those briefs have raised highly significant and valid concerns with respect to Bill 173 as presently drafted. Among those organizations are the Catholic Health Association of Ontario, the Canadian Red Cross Society, the Canadian Association of Retired Persons and the Ontario Home Health Care Providers' Association. Each of these organizations, from their different perspectives and with the benefit of their individual organizational experiences, came to remarkably similar conclusions with respect to the deficiencies in Bill 173.

To summarize, it is a fundamentally flawed bill that needs not Band-Aids but rather major surgery.

As the basis for a new approach to the improvement of home care services, we concur with the specific principles as put before this committee by the Ontario Home Health Care Providers' Association:

"(1) The government should determine what services it can afford to provide and make those services available in an equitable and consistent fashion across the province.

"(2) Local communities should ensure that services are provided as efficiently and effectively as possible through managed competition among all providers.

"(3) Consumers should have much more choice in the services they receive as individuals rather than having to fit into a specific program.

"(4) The development of a client-focused information system which integrates community and facility care services must be a priority.

"(5) The government must give local communities the resources and responsibility to allocate resources at the local level. The Ministry of Health must stop trying to manage day-to-day operations of home care."

We have offered some positive suggestions on the ways the home care system can be improved to meet the needs of consumers while maintaining the essential qualities of the current system, such as competition, consumer choice and local autonomy.

**1550**

We conclude by stating our final point more simply. The creation of multiservice agencies as envisioned under Bill 173 is not the answer to the improvement of home care services in the province of Ontario. Our concluding plea to the standing committee and, through you, to the government of Ontario is that we build on what we have, that we coordinate and rationalize what we have, and that we work to evolve improvements in what we have, rather than destroy what we have.

We urge that the concept of a newly created multi-service agency mandated to plan, manage and deliver home care services be set aside, that the whole issue be revisited, and that the principle be to firstly look at the rationalization of services and then at the delivery agencies, and not vice versa.

We conclude by again expressing our genuine appreciation to the standing committee on social development for the opportunity of making this submission to you from the county of Renfrew. If you have any questions, obviously, Michael or Warden Stone will be able to answer.

**Mr Jim Wilson:** My appreciation to the county of Renfrew. I can tell you that we've been waiting a while for groups to come forward and, in as forthright a manner, say what you've said. Many of the conclusions that you've come to, and you note some other organizations that came to similar and independent conclusions, are the same as the ones we've come to.

I really appreciate your section on buzzwords, as a politician, because I've long said in my remarks in the Legislature that we're drowning in our own political correctness. You mentioned things like "bottom up, community-driven, accountability." I often wonder about "stakeholders." I assume they mean human beings. "Reform" means less services, less of everything. "Employment equity" means quotas. We've got all kinds of things. "Consultation" means, "We've made up our minds, so let's go to the people."

It's gotten ridiculous. It comes out of 20 years of a particular party around here which has been changing the vocabulary of the people of Ontario, but their day will come up, and the good news might be that I doubt they'll be around long enough, the NDP, to actually proclaim this legislation.

I'll also tell you one other theory that I certainly have, and it's not a popular one with the government, but if you know our new labour laws in Ontario and if you take into account that the majority of the home care sector, the community support sector, right now is not unionized, if you under this legislation take all those groups, destroy

them, put them under one roof, combine them with the new labour laws, you have one-stop unionization. It makes it much easier.

OPSEU in fact was before us and they complained that the bill didn't go far enough. So they're not even happy with it. But we know that that's part of the mix here too, and I think that actual efficiency in services and all the things that you mentioned on behalf of the county of Renfrew are a lesser concern to the government, and it has been the hidden agenda. I'm glad we had the opportunity to say this because you came forward in such a forthright way.

I do want to talk about costs, though, and the question is, have you got any idea now or any rough estimates or ratios or anything about what the cost might be in Renfrew? Because I assume in Renfrew you're doing things like they do in Simcoe county, and it's a fairly commonsense approach to the delivery of services right now, and in certainly my area of the province, we don't see the need to reinvent the wheel either.

In fact, in a close examination of Simcoe county, we're coming to the conclusion that a lot of these little agencies have very small administrative structures, and with a bit of cooperation we shouldn't have to go through Bill 173 and tear them apart and reinvent the wheel. But what's the situation like in Renfrew?

**Mr Michael Johnson:** The situation in Renfrew county is I think rather similar to that which you have described in Simcoe. Through the Renfrew County and District Health Unit for a very large number of years, a large number of different local organizations have been delivering the home care services, and the health unit then itself with their staff attempts to fill in those gaps which the other organizations are not able to meet.

The efficiency of those small organizations is a tribute to the volunteerism that we attempted to speak to in our brief, and a credit to the financial responsibility of the management of those organizations that they are able to effectively deliver home care services through the overall auspices of the Renfrew County and District Health Unit at the kind of cost that they're able to do it at.

**The Chair:** I regret we don't have more time, but I want to thank you for the presentation that you've brought before the committee today.

**Mr Sterling:** Mr Chair, just on a point of order: maybe the warden would like to tell us what's happening in Renfrew county next week.

**The Chair:** Fair enough. We all expect that would be something that would have the support of all members. Warden, why don't you tell us what's happening next week?

**Mr Stone:** Thank you, Norm, for the opportunity of course to invite everyone who's in this building to the international plowing match in Renfrew county next week, just on the east end of the city of Pembroke. I'm sure that anyone who comes along to join us next week will thoroughly enjoy themselves. I understand there's one million square feet of tents in this city for the international plowing match.

**The Chair:** Thank you. We'll see you at the match.

ONTARIO HOSPITAL ASSOCIATION  
ASSOCIATION DES HÔPITAUX DE L'ONTARIO

**The Chair:** I call on the representatives from the Ontario Hospital Association, please. I don't know whether we should ask the OHA if they're also good plowmen, but gentlemen, we welcome you to the committee.

**M. Laurent Isabelle :** Bonjour, Monsieur le Président, mesdames et messieurs. Permettez-moi de présenter mes collègues Michel Bilodeau, président du CHMCO, ou CCHO en anglais, the Council of Chronic Hospitals of Ontario, et Dan Drown, senior consultant of the Ontario Hospital Association division dedicated to chronic care, mental health and rehabilitation, policies and services.

Je m'appelle Laurent Isabelle. Je suis président élu ou désigné, chair-elect, de l'Association des hôpitaux de l'Ontario et j'ai la tâche plaisante de représenter l'Association des hôpitaux de l'Ontario ainsi que la CHMCO, et de vous transmettre nos commentaires ainsi que nos recommandations quant au projet de loi 173.

OHA is a voluntary organization, and suffice it perhaps to say that it is a voluntary association of 200-and-some hospitals, 17 of which are chronic care hospitals, and we are celebrating our 70th anniversary this year.

**Le Président :** Bonne fête.

**Mr Isabelle:** The association is governed by 26 trustees, male and female trustees, volunteers all, and some CEOs, all of whom have been elected to that office by their peers.

OHA, in speaking for itself and CCHO, has five major concerns, therefore five major recommendations, in order to perfect the draft Bill 173: (1) we find the approach too prescriptive; (2) we find that MSAs or multiservice agencies as proposed are a rigid, top-heavy, bureaucratic, one-stop access to care; (3) we find the thrust is adversarial because it pits institutions, hospitals, against community-based systems of care; and (4) and (5) are our concerns about district health councils, regional planning and resource allocation.

Or, dans cet ordre :

(1) The prescriptive approach: Bill 173, as did its predecessor, Bill 101, the Long Term Care Statute Law Amendment Act, in our view is micromanagement. Although government says it is seeking to promote local autonomy and advocating devolution of power, we see the structure as a top-heavy, rigid, bureaucratic one, and it's centralized control.

Forty-two areas of regulation: we see that as total control by government for long-term care services. We see that as an unnecessary, unwarranted intrusion in the autonomy of individual organizations and providers. In fact, we see that as an indictment of the volunteerism of which we in health care are so justifiably proud.

We cannot support for the consumer, indeed for the taxpayer, legislation that promotes additional layering or more government-controlled bureaucracy which widens the gap between policy-making and delivery of services. We believe the MSA model as it now reads will lead to eventual usurping of the governance and management responsibilities of community-based organizations,

including hospitals. May I add that acute care hospitals with chronic care beds and the 17 chronic care hospitals are equally concerned by this draft.

**1600**

The association, speaking for CCHO as well, recommends, one, that section 56 of Bill 173 be amended to allow local bodies to determine volunteer involvement and activity, local bodies to determine and to apply quality standards and operating guidelines to meet the criteria, and we add national criteria, of an accrediting body called the Canadian Council on Health Facilities Accreditation, and to allow local, individual communities to create efficient, responsive administrative structures.

(2) Multiservice agencies as one-stop access: We have supported the concept of one-stop access to long-term care services since the 1970s. We continue to support functional integration of information, referral, assessment, case management, service delivery, coordination and follow-up for consumers in need. What we cannot support is one-stop shopping. We find that it is not warranted. What is needed is more choice, high-quality services and local access to these services. Bill 173, as it now reads, potentially leads to the very opposite.

We feel there is an indictment of services provided by hospitals, services which are appropriate, which are accessible, which are timely. For example, many hospitals, acute care and chronic care, provide community support services such as outreach palliative care programs, home care services, respite care, meal programs, security checks and lifeline programs.

Many hospitals are closely affiliated with or manage long-term care facilities. Numerous local hospitals are the hub of community-based long-term care. We feel the one-stop shopping approach will jeopardize many of these excellent initiatives. It is not clear how or if these are to be integrated within MSAs or whether they will be viewed as institutionally based or community-based.

Our members believe the long-term care services already being provided are vital, they are working successfully, they're staffed by highly skilled personnel and they're supported by knowledgeable volunteers and, I might add, dedicated volunteers. These services must be recognized and funded in order to continue.

As it now stands, Bill 173 limits the number of participants, and we refer you to section 13, which limits the purchase of services outside MSAs, or it causes or forces agencies to be part of the MSA itself.

It is not clear either, in Bill 173 as it now reads, how MSAs will affect the current coordination of services for children.

We therefore recommend to amend Bill 173, and this is our second recommendation, by removing the restriction on the amount of services that can be purchased from the other service providers by MSAs.

(3) Institutional versus community-based systems of care: Bill 173 upholds the important principles of reducing inappropriate institutionalization and strengthening non-institutional care, or what Bill 173 refers to as community-based care.

En passant, j'ai encore à voir un hôpital qui se croit ne

pas faire partie de sa communauté, et ça fait quand même plusieurs années que j'oeuvre dans le domaine.

Both OHA and CCHO support and have supported those basic principles. Hospitals are an integral part of their communities. They provide services which are deinstitutionalized, they shift in-service delivery to outpatient care and they provide community-based services, and these in our view are all clear illustrations of commitment to providing care close to a person's home.

Why does government continue to or appear to present institutional and community-based care as mutually exclusive rather than parallel pathways or partners of a continuum?

The compendium to Bill 173 states that institutions are often viewed as a last resort. Are they not also viewed as a point of renewal or a point of transition or a point of rehabilitation or a place where patients are assisted in their efforts to return to their home community?

We therefore strongly recommend that, three, the government abandon this very highly structured approach. Indeed, we recommend that government thrusts to reform long-term care do so by building on existing community resources, including the role hospitals play in delivering long-term care services.

In fact, our third recommendation can be interpreted as the Health minister's very own recommendation to the Metropolitan Toronto District Health Council as found in her letter of May 13, 1994, concerning interim MSAs, and I quote: "An interim or transitional strategy may be a federation of long-term care agencies agreeing to work together to provide services for a particular area." In our view, such a federation allows for the inclusion of hospitals to ensure a continuum of care.

The minister's interim model of an MSA does not require the degree of regulation called for by Bill 173. Her interim model was flexible, it endorsed local decision-making, it used the best agency to do the job and it respected existing volunteerism in all of these institutions.

(4) Local planning of services under the leadership of district health councils: In our joint paper almost a year ago, we stated:

"We feel that the district health council is currently the most effective mechanism for local planning. We fully support the DHC as the instrument through which multi-year plans should be developed, to initiate multiservice agencies and to develop local implementation strategies."

We stressed the need for data and information collection so that local planning could be done based on objective, information-based decision-making as stated in the government's Partnership Planning Framework document. OHA still holds that position. However, we find that DHCs are burdened by heavy workloads and thereby hindered in their ability to effectively plan. They are currently involved in 12 of the ministry's priority reform areas.

We had commented that DHC long-term care committees should establish appropriate membership balances of consumers, providers and other interested parties.

1610

OHA also expressed concern with the proposal to

establish long-term care funding envelopes for districts in the absence of sufficient information regarding costs, effectiveness and quality of existing programs.

Nous déclarons, à ce sujet, à l'heure actuelle les conseils régionaux de santé ne disposent pas de l'information voulue pour répartir convenablement l'enveloppe locale, qui puisait. Le projet de loi 173 incorpore les conseils régionaux de santé dans la loi pour la première fois en modifiant la Loi sur le ministère de la Santé et définit les fonctions des CRS.

L'article 62 du projet de loi indique que les CRS agissent à titre d'organismes consultatifs auprès de la Ministre en matière de besoins de soins de santé dans leurs régions géographiques respectives. Ce même article préconise que les CRS passent des recommandations sur ce qui suit : la répartition des ressources pour répondre aux besoins de la région géographique en matière de santé et les plans de création des services de soins de santé équilibrés et intégrés. On brouille ici la distinction importante qui existe entre planification et gestion en confondant l'autonomie des organismes particuliers et l'administration et la gestion de leurs responsabilités.

L'article 62 préconise aussi de donner au CRS le pouvoir d'accomplir toute autre tâche que la Ministre pourrait lui attribuer. Ce pouvoir considérable est inquiétant en soi et perpétue l'ambiguïté continue du rôle et du mandat des CRS. L'appendice du projet de loi indique : pour que les CRS soient capables de bien s'acquitter de leurs responsabilités de planification et de fournir des conseils fructueux à la Ministre, il faut établir clairement ces responsabilités et la délégation qu'en fait la Ministre au CRS. Le projet de loi ne fournit pas cette orientation. Le mandat qui peut comporter un pouvoir considérable et pourtant vague que propose le projet de loi 173, soulève de nouvelles inquiétudes au sujet de l'avenir de ces organismes.

L'Association des hôpitaux de l'Ontario recommande que, par conséquent, et c'est notre quatrième recommandation : l'article 62 du projet de loi soit modifié pour que l'on incorpore à la loi que les CRS, comme organes de planification et organes consultatifs auprès de la ministre de la Santé, et que tout pouvoir supplémentaire attribué aux CRS ou à tout autre organisme défini géographiquement, fassent l'objet d'un processus séparé faisant appel au débat public et à la consultation de tous les intervenants.

Finally, our concern number 5, regional planning and resource allocation: In the June 1994 final report of the minister's regional planning steering committee for southwestern Ontario, chaired by Douglas Lawson, a proposed new model for regional planning is recommended. Health Minister Ruth Grier has endorsed this proposal.

The Lawson report outlines an approach to regional planning through adding a new layer of bureaucracy. It proposes the creation of a regional health council, or RHC, for southwestern Ontario which will have a permanent staff of at least five, including an executive director. The RHC would have a similar scope of authority and responsibility as that of DHCs and, as the Lawson report states, "The authority of the RHC will evolve along

similar lines to any future changes in the scope and breadth of the DHCs...."

Thus any ambiguity about DHCs resolved through Bill 173 is negated by the creation of an added higher layer of bureaucracy which lacks any legislated authority and to which DHCs will be subordinate.

As noted earlier, the Minister of Health has endorsed the proposed regional structure for southwestern Ontario and ministry officials have indicated that the implementation process is already under way. The Lawson report has been sent to DHCs in other regions for consideration in designing new regional planning structures. All this has occurred without any opportunity for public input or stakeholder consultation.

OHA not only urges that before the RHC process goes any further, it recommends there be considerably more debate and discussion in the public arena and that it be made clear in Bill 173 that any regional health care planning structures will not be created under the sections of this bill dealing with DHCs.

Finally, section 62 of Bill 173 should be amended to make it clear that no member of a DHC should receive remuneration as a council member. The same must be said about RHCs, if and when they develop.

Volunteerism in health care in Ontario, indeed in Canada, has long proven that it is competent, effective and that its aptitude for cost containment, not forgetting fund-raising, is legendary.

Conclusion: While we support the principles of long-term care reform, we cannot support Bill 173 in its present form due to its overly prescriptive approach, its inability to achieve the concept of one-stop access without the potential dismantling of high-quality volunteer programs and the artificial separation of institutional and community-based care. In addition, the complexity of issues surrounding DHCs and the new regional health council structure being established in southwestern Ontario and possibly elsewhere should be publicly debated and discussed.

Il va sans dire, sans doute, que nous avons apprécié l'occasion de vous présenter nos recommandations et que nous vous remercions de votre attention à tous nos propos.

1620

**M. le Président :** Merci pour votre présentation. On passe maintenant à M<sup>me</sup> Gigantes.

**Ms Gigantes:** Mr Isabelle, thank you for your presentation. I was interested in listening to understand that of course you're presenting not just from the base of experience here in Ottawa-Carleton, which you have certainly personally, but also on behalf of hospitals, both acute and chronic hospitals, on a provincial base. It's in that context that I would like a few further comments from you, if I could, on what I sense is a kind of—"defensive" is probably not an appropriate word, but anxious attitude that seems to me to come forward in your brief on behalf of hospitals in Ontario about their role, not only in long-term care as Bill 173 contemplates it—and you talk about an artificial division which the government is putting forward between hospital care and

community-based care, which I don't believe is there.

You're expressing an anxiety about that but also an anxiety about the role of district health councils. On the one hand you approve the planning vehicle offered by district health councils; on the other hand you say they don't have enough resources at the moment to carry forward their mandates, and I would agree with you that they are going to need increasing resources. On the other hand, when you look at the potential of development of regional district health councils, for example, the size and scope of southwestern Ontario, again that anxiety comes out: "Where do the hospitals fit in?" So overall what I'm reading from your brief is a lot of anxiety. Why are hospitals so frightened?

**Mr Isabelle:** Well, I'm going to ask one of my colleagues to help me with that, but, number one, it's by what we read. We find that there are contradictory statements between government intentions and what is drafted, as I've indicated in my paper. Number two, we have supported district health councils, yes, that's true, and yet we also recognize that, like a lot of other people in the province, they have to be enabled to do their job. However, we find that the legislation for district health councils is in a paper dealing with long-term care. Why not a separate legislative bill?

Now, with respect to the other comments, Madame, I'd like to refer to Dan Drown, if you accept.

**Ms Gigantes:** Have you ever tried to get a bill through?

**Mr Isabelle:** Dan, could you please address the other concern she made?

**Mr Dan Drown:** I think the issue of divisiveness or anxiety stems from the fact that we run into very different approaches towards management, for instance, between the two sectors of what we call long-term care, community care and hospital care. We'd like to see a greater twinning, if you will, or a pathway concept whereby we do not see a highly regulated sector adjacent to hospitals but in fact we lean on what we've learned about voluntarism, what we've learned about accreditation standards.

In effect we're not, I think, as anxious as we are perhaps frustrated by the inability to manage in a continuum fashion or create a pathway. You know, people enter and exit pathways, and in doing so, you can devise treatments which are also along the continuum basis. So I think the anxiety is more frustration in the fact that we run into very different sort of legislative mandates to accomplish the same continuum or pathway of care.

**Ms Gigantes:** The district health council representatives before us drew to our attention the fact that 94% of the long-term care budget that's spent on community service in the Ottawa-Carleton region goes to four agencies which are providing service in blocks and in disjointed ways, as we know it, in the community, without the kind of rationalization I'd expect you, with your interests in planning, to understand as a need within the community. If that changes, why is there a threat to the hospitals?

**Mr Drown:** In my mind, as long as you're dealing

with enabling legislation which allows the needed flexibility, you wouldn't have a problem with bringing those things together. In fact, I think if you scratch the surface, you'll find that those community agencies may well be located in hospitals, in some instances, in terms of where the origin of the service is.

**Ms Gigantes:** Seventy per cent are in the private sector.

**Mr Isabelle:** Seventy?

**Ms Gigantes:** In Ottawa-Carleton, yes.

**Mr Michel Bilodeau:** If I may add to that, I think the level of anxiety may not be as high as you may think. There are two specific things that we say in the OHA brief. One is that we are concerned that the legislation is open-ended as regards the role of the DHC. Certainly we have no problem with the role of the DHC as a planner, but when it says that the DHC may have any other role that the minister decides to give to the DHC, that we are concerned about because we don't know what it is.

Second, we have concerns about the process that has been followed in southwestern Ontario, where basically hospitals have been put aside for the planning of the new system and are not yet involved fully in the process of regional planning. So these are our two main concerns.

**The Chair:** I'm sorry that I'm going to have to jump in here. I hope we've relieved some anxiety somewhere, but we have to continue. Merci pour la présentation de cet après-midi.

**Mr Bilodeau:** I'll stay here.

**M. le Président :** Monsieur Bilodeau, vous allez rester avec nous.

#### SISTERS OF CHARITY OF OTTAWA HEALTH SERVICE

**The Chair:** The next presentation is on behalf of the Sisters of Charity of Ottawa Health Service.

**Mr Michel Bilodeau:** Thank you, Mr Chairman. This time I wear my other hat in my day-to-day job as president of the Sisters of Charity of Ottawa Health Service, which is commonly called the SCO Health Service.

The SCO Health Service has been created in early 1993 to bring under one board and one administration the four health care institutions owned and operated by the Sisters of Charity in Ottawa-Carleton, and that includes Saint-Vincent Hospital, a chronic care hospital and rehabilitation hospital with 516 beds; Élisabeth Bruyère Health Centre, which has 225 beds in the chronic, rehabilitation and palliative care sector; the Residence Saint-Louis, a 186-bed charitable home for the aged; and Villa Marguerite, a 71-bed not-for-profit nursing home.

In total, we provide 741 hospital beds, 257 long-term care beds, 26 detoxification centre beds, 30 spaces in day hospitals, and we serve close to 70,000 outpatients. We have a total of 2,200 employees and we have more than 1,000 volunteers who devote their time to our clientele.

I may add, which is not in your brief, that our board meetings are public, that we have direct nursing representation on our board and that we have community advisory committees that include the patients themselves and their families. We are therefore directly impacted by the long-

term care reform, by the chronic care reform and by all the changes taking place in community services, including the establishment of MSAs.

I have numerous comments, but since you heard a lot of statements about Bill 173, what I'd like to do is concentrate on examples, real cases of what it will really do to some agencies and some organizations.

First of all, obviously the idea of one stop for the elderly is a good one. However, my question is, how will it work in reality? You're an elderly person. You call to one number. Now, it's not Pizza Pizza. They're not going to deliver you the service within one hour or half an hour. This receptionist or telephone operator will have either to have all the answers to all the problems, or if that's not the case, which may happen, she or he will have to refer the caller to somebody else, maybe a social worker or a case worker, and in turn, this one will have to talk to a service provider.

All of these people will have somehow to have information about the client who's calling. Just in Ottawa-Carleton there are 100,000 potential customers to be served by MSAs. Currently, several hundreds of small agencies have information about these clients, information that's in fraction in each of these agencies. If we want to have a real one-stop, we'll need to have a central file on each of these clients.

Just for the fun of it, talk to a computer company and try to centralize 100,000 charts with information that you have all over the place, and try to have significant information in there without having, first, a computer service with a lot of people in it, without having a lot of computer terminals that will have to be accessed from all the providers and all the case workers. Now, we're talking, to be realistic, millions of dollars province-wide to do that, and this is money that will be diverted from current direct services to the clients.

A lot of people talk about the 20% rule, and I'll come back to that later with a direct example. A lot of people I talked to were under the impression that it was for the private sector only. Well, this is not what the legislation says. It's for everyone, and it's a sure recipe to create a huge bureaucracy.

Let me give you a few examples, and I'll come back to bureaucracy later. Part II of the bill identifies "security checks or reassurance services" as mandatory community services provided by the MSA. We in one of our institutions offer a service called Helpline where clients have an alarm at home which is monitored 24 hours a day from one of our sites. We have staff working 24 hours a day because we operate a hospital.

Now this service, which we created ourselves in the early 1980s, at a time when nobody else wanted to create that, is supervised by a community board of something like 20 people, which includes the police, the firefighters, the ambulance dispatch centre, consumers, community workers, and we have about 30 volunteers who devote their time, going to houses, install the system and help with operation of the system. Now, is that a community service or an institutional service? I don't know and I don't care. The service is working fine; we have more than 700 clients now and people seem to be satisfied.

## 1630

When, because there's funding from Comsoc, will that likely be included in the MSA? Will the efficiency improve? Will the clients be better served because the service we've been providing for 11 years now will now be under the MSA? I can't see any answer to that question in the bill or in the MSA project.

Part II also identifies "adult day programs" as mandatory service. We currently in our building rent at subsidized rates, \$5 per square foot in an area that commands around \$21 rent, and we pay for housekeeping. We rent space to two of such adult day programs. One is the Alzheimer day away program that's operated by VON and another one is a day centre for senior francophones.

These two services, when I talk to them, are convinced that they're becoming part of the MSA because they're funded by Comsoc in large part. Their administration costs are extremely low. They operate well. They're controlled by their clients right now. Why change them? And on the other hand, why would we rent to the MSA at subsidized rates?

I mention bureaucracy. As all these services are merged under the MSA, there will be a time, it will come very soon, when the MSA will have more than 50 employees and, with our 2,200, I know what I'm talking about. Then, as an employer, the MSA will be covered by the pay equity legislation, the health and safety legislation, the employment equity legislation. Soon employees will be unionized, and I have nothing against that, but I can assure you that salary costs will be driven up very, very fast.

To manage that you'll need a human resource department because you'll need to prepare the pay equity legislation and the employment equity plan, and these are very complex issues. When you have that, you'll need a payroll service and, in addition to your computer service that was created earlier, you'll need financial services and then you'll need a purchasing service to have all of these small agencies purchase from the same place. When the administration was done by volunteers before, it will now require professional staff to manage this place because it will be bigger.

With higher salaries and higher overhead costs, less services will be provided with the same amount of money. Is that making the system more efficient?

I can talk about mergers. I've been through a merger in the last year and a half of four organizations and we saved a lot because we merged services that were already bureaucratic. We merged large organizations that all had a lot of bureaucracy, but if you merge services that have no bureaucracy, that are managed by volunteers, you'll have to create the bureaucracy and I don't think you'll be solving the problems.

One option currently under review is to have several MSAs in a region. I've heard in Toronto, they're talking about one MSA for about 100,000 to 150,000 people. If that's the case, we'd have three or six MSAs in the Ottawa region. If that's to happen, not only the 20% ceiling becomes problematic, it just doesn't make sense. Let me give you the example of the Helpline I mentioned

earlier. We have one service for 700 clients in the region. If we have five MSAs, will we duplicate and have five helplines and make them less efficient or will we have one MSA which will integrate the helpline and sell the services to the four others?

For the client of the MSA that purchase the helpline service from another MSA, what's the difference to purchase it from another MSA or purchase it from us? There's absolutely no advantage. If you create one giant MSA, yes, maybe you can think of a 20% ceiling, which I think is not good anyway, but if you have five or six or several, it just doesn't make sense any more. The Alzheimer day away program—there's one program, two in town. If you have five MSAs, how do you split that? Who controls these Alzheimer day away programs? You'll tell me it may be part of the 20%. Well, the 20% will be blown very, very fast.

Wouldn't it be simpler to maintain these programs as they have now and have each of them contract with the MSAs? This would avoid the dismantlement of well-established programs and achieve exactly the same goal without disruption to the consumer. That's what you heard today from the district health council. That's what you heard today from the council on aging and I'm sure from a lot of other organizations. Why force a region to adopt a model it doesn't want?

In addition, because of the creation of MSAs, cultural groups which currently control their own services may well lose this control. Le centre de jour des aînés francophones, the adult day centre to which we currently rent space, has its own board made up of the members of its organization. It has several hundred members. They elect their own board. If they become part of the MSA, as they expect to be, their board will be formed mainly of English-speaking people, unless we create a French MSA only which will create other problems. But why would an organization that's been operating well and controls its own destiny with people from its own language suddenly have to have a board that is mainly made up of anglophones? How will it serve the citizens better? That's the question you should ask yourself.

In conclusion, we recommend that section 13 be amended to delete the 20% maximum for purchased service and if the government wanted absolutely to maintain a ceiling, we think this ceiling should not apply to other public health or social service agencies that already provide similar services. We agree that the MSA should play a coordination role but not an integration role.

**Ms Gigantes:** Mr Chair, could I just ask on a point of order: If one feels that a witness, with all due respect, has attributed to another witness something that I believe the other witness did not say, what does one do? Because I do think there has been a misunderstanding—

**The Chair:** One does what you are doing, so just go ahead with your point.

**Ms Gigantes:** —on the part of this witness of the points that were made by the district health council and I'd be happy to give him a copy of the brief.

**Mr Bilodeau:** The only point I mentioned about the

DHC is that they oppose a 20% ceiling. That's all I said about them.

**Ms Gigantes:** Well, no, your brief says something else. It says this is what the district health council wants and it says—

**Mr Bilodeau:** I'm referring to the 20% ceiling.

**Ms Gigantes:** "Wouldn't it be simpler to maintain these programs as they are now and have each MSA contract with them." That's not what they propose.

**Mr Bilodeau:** No. If there's a misunderstanding, I want to clarify. The only thing I want to attribute to the DHC is that they oppose the 20% ceiling, and my sentence may have not been clear. It's clear in the French text that the only thing I mentioned about them is the 20% ceiling.

**Ms Gigantes:** Thank you.

**Mrs O'Neill:** Well, Michel, I'm glad to see you again and the four organizations or facilities you're representing today—their reputation precedes them. I'm surprised you didn't mention a little more of something that we're not talking about a lot here, and that is the relationship of the facilities to the community agencies and how you see that changing if Bill 173 goes through as is now. Facilities, if I am judging the situation correctly, have not really been significant partners in this discussion. They are significant partners in reality, but Bill 173 does not talk about facilities. All of the partnerships you've built up and so well exemplified this afternoon, I feel, are somewhat in jeopardy and I wonder what you could say about that. It looks to me like less service and longer waiting lists even in things you're trying to offer at the present time.

**Mr Bilodeau:** I must say I'm not very much concerned by that, at least in this region. We've had, as facilities, very good relationships with district health councils. We participate, for example, in the definition of what the MSA will be. We have representation on the long-term care committees. As you know, we've operated with a placement coordination service for a long, long time and we may even avoid losing our cultural identity at the residence although I think we'll lose it anyway in the long run because of Bill 101, but I'm not very much concerned. I think in this region at least, facilities have been involved in the planning process through the district health council. I cannot speak for other regions, but in Ottawa it's not bad.

**The Chair:** Thank you very much, encore une fois, d'être venu devant le comité cet après-midi.

1640

#### OTTAWA WEST SENIORS RECREATION ADVISORY COMMITTEE

**The Chair:** I call the representatives from the Ottawa West Seniors Recreation Advisory Committee. Welcome to the committee.

**Mr Tom Sparling:** My name is Tom Sparling.

**Ms Karen Colby:** Karen Colby from Central Park Lodge retirement home.

**Ms Lindsay Webber:** Lindsay Webber. I'm a recreation therapist in geriatric psychiatry at the Royal Ottawa hospital.

**Mr Sparling:** We noted in the information package that was so kindly sent to us by the clerk that brevity was an important issue. After sitting through part of the meeting, I can appreciate that and I will promise that we will be brief and to the point. I'd like to thank the committee, the support people, for their efficiency and also the committee itself for being kind enough to hear us.

This afternoon, what I propose to do is very briefly—if you just look at page 3 of our presentation, we'll just take you through 3 pages, come back for our recommendations and conclusions and then provide time for questions and answers if the committee so chooses. Again, thank you for allowing us to be present.

I'm going to give you a little history of how we got here. The Ottawa west area has a very high concentration of seniors, those living independently and those receiving some level of support in their own homes or in public or private sector facilities. We've noted that the independent seniors are well served by municipal recreation programs, community centres, senior activity centres and the YW/YMCA. As a matter of fact, the last time I checked you sort of had to inherit a spot on the aquafit program at the YMCA. It's a very, very busy facility, and they're doing a fine job.

But who are we? If we go back to our front page here, we've got the Beacon Hill Lodge, which is a nursing home. I look after the recreation volunteer program at that facility. We have Carleton Lodge which is the home for the aged in Ottawa-Carleton. We have Central Park Lodge which is a retirement home. We have the City of Ottawa Senior Adults' section as a partner, the Dovercourt community centre which is a personal service community centre operated by a community board, the Queensway-Carleton Hospital, the Royal Ottawa hospital and West-End Villa. That's the initial group we're working with here. That's the week.

We realize that a group of seniors living in their homes, homes for the aged, nursing homes, retirement facilities and the community in general share a number of characteristics. Some of those shared characteristics may be a certain lack of mobility, perhaps a need for a wheelchair, using a walker, that type of thing, or perhaps a lack of confidence. A lot of the people we work with have lost their confidence in their abilities to cope in society.

Every time we reach out to help someone, we also take the ability away to stand on your own two feet. It's a little bit like learning to ride a bicycle; we have to find at what point one lets go of the back tire and allows the individual to have responsibility and to be successful, even if it's a very small step.

So we think that the lack of confidence, sometimes in your ability to be independent, can affect people greatly. We sometimes see the issue with the clients we work with of recreation as a foreign concept. Leisure was something that most of the people we work with did not experience. They grew up through the Great Depression, one or two world wars, and they were busy building a country. For most of them leisure was something they did not have the opportunity to be involved in. A few do

have leisure and hobbies that we work with in the long-term care setting; others in the community may have developed interests after retirement. We suggest that the idea of new skills can be daunting to people who haven't had that opportunity or the education to say that it's okay, it's all right to have a hobby, it's all right to do something called play for the joy of it.

I think we're also aware that for the people we were serving, these characteristics are very human. We all have failings and fears and anxieties as we go through our daily living. We think it's important that we realize these are the same types of issues that we all face.

We felt that therefore some support and organization could be provided to these seniors who tend to be excluded from community recreation programs. We could become involved in a new type of what we call adaptive recreation programs.

What we're trying to do is bring together seniors from various locations. For example, there could be clients from the nursing home, clients from our senior apartment buildings that are funded or administered by the Ottawa-Carleton housing authority, people from retirement homes, homes for the aged, or people living independently in the community who may be clients of one of our home support agencies or who just happened to hear about a program that was going to be offered at a community centre or other service point.

We're actively seeking the people who had fallen through the cracks, and in part for the people who are working in facilities, ourselves. The issue is for us to maintain a continuum of recreation programs so that the people who do have the confidence, who do have the interest in maintaining community contacts, can be supported and encouraged in being out of facilities so in fact it is a home and not a facility, not an institution. We have people who want to reach out and maintain contact to make use of facilities the way we all would like to use facilities in the community: the library, the pool, the maintenance of service clubs etc.

We looked at these people and we said that there's no doubt there is a clientele, perhaps, here that would meet the needs of some of our people, some of the people living in communities with some support, and that together we might form the basis of some very interesting program ideas. What we sought to do was to bring together these groups of people, and in fact we've done that on two occasions, where we brought together in one case 120 people and, more recently, almost 170 persons at the Dovercourt community centre. What we found on that day was a real interest in some things that were new to these people. Weight training—I have some photographs with us. Unfortunately, all the shots from the weight training have gone to those participants. I couldn't get them back from them because it was exciting for someone 80 years of age to realize that they could, and it was indeed possible to, look at weight training as an option, as something they might like to do.

The chair fitness programs, the water programs, the adapted program for people with special needs in the water, all can be done and provide an exciting new opportunity for these people from a number of environ-

ments who share the same characteristics, regardless of where they live.

Indeed, this fall we're going to be offering a t'ai chi program and creative writing programs. We're in partnership with the Ottawa-Carleton department of health and its Healthy Neighbourhoods program in the Lincoln Fields shopping mall, and there's a craft program under way now that has clients from the community and long-term care, and we're hoping to have residents involved in a mall-walking program. It's the teamwork and building of services and linkages between service providers that we think is important. All these programs and more we think are possible.

Assuring that there is a user-friendly environment: I think trust is a critical issue for all of us and especially people who have a sense of perhaps diminished abilities; that when they're in a situation where they can feel dependent, it's important that they know you and that there is a trust developed. I think that's a critical component of care, that people need to trust those they're working with.

#### 1650

This fall we're offering a number of programs that we've alluded to: the mall-walking, a creative writing program, the t'ai chi—a number of things where we'll have clients from the community at large, people from other long-term care facilities, and opening up spaces, opening up new horizons to people.

We're at present an eight-member committee. We expect to grow between now and Christmas to perhaps 16 persons. We've had discussions with the city of Nepean and with indeed interests from Kanata as well, from the possibilities of linking up further the information, sharing that information, sharing facilities, and doing what we can to improve the quality of recreation service for people living in the community and also living in facilities.

Recreation, we believe, is a very important and cost-effective means of maintaining increasing wellness in seniors. We would ask the committee to recommend that recreation professionals such as ourselves, people in the field, other organizations such as the Activity Professionals of Ontario and an eastern Ontario group called the Health Facility Therapeutic Recreation Association, be consulted and involved as the process moves forward.

We think that another issue that needs to be addressed in the future is the issue of pay equity down the road. There is at present a difference between the level of salary between those working in different sectors, and I think that needs to be looked at. I know there are a number of things that you folks have on your agenda right now, but somewhere along the line we would appreciate some consideration of that issue.

Professionalism: We think that it's critically important that a team deal with the issues in the community, whether it's the therapist, whether it's the dietician, whether it's the medical personnel or perhaps whether it's the recreation staff person. All the skills together will, I think, provide the best possible mixture for the clients we indeed wish to serve.

The last thing is the note that in British Columbia some work has been done with regard to improvements and in the modelling for recreation professionals between the community and the long-term care setting; that there's been some work done with regard to the Therapeutic Recreation Association in British Columbia looking at improvements to education.

I think that's also a critical issue, that if we're going to have people working in the profession, the present situation at college and university may not be able to meet all the demands that we're facing. I know that at University of Ottawa, where I studied recreation, there was only one program in adapted rec, and indeed there may be a greater need for educational programs and upgrading across Ontario.

We'd also like to point that there's some reference material. I think Biomarkers is a wonderful book. There's a very interesting title called "Postponing Your Entry Into the Disability Zone." I think it's worth all of us reading, because that's a critical issue. If we can prevent people going to long-term care or needing support, then we're going to save us all an awful lot of money. I hope we get this right by the time I get there, speaking personally.

In conclusion, we'd like to make a couple of recommendations.

First of all, we'd like to recommend that recreation professionals play an active role in long-term care, be it community or facility based.

We'd like to also recommend, respectfully I might add, that the recreation professionals and the professional organizations must be consulted and involved in the development of criteria and guidelines for recreation services.

I think that the third item is, the delivery of service to long-term care clients must truly be a multidisciplinary approach to work effectively.

Item 4 is that we suggest that the multidisciplinary team should include medical, dietary, therapeutic, social service and recreation professionals.

In terms of conclusions, we have but four:

(1) We think to realize the goals of long-term care reform, the system must be integrated, as facility-based care and community support are but two sides of the same coin. Information needs to be exchanged, and I think that it's possible down the road to see people going into long-term care for a short time and then going back into the community. Indeed, that's one of the goals of the program and I think we should continue to push for that.

(2) We have shown that close cooperation—our little experiment—and networking will provide a better and more cost-effective service to clients whatever their location. I think that it's important to remember that efficiency and making wise use of scarce resources is why we're all here today.

(3) We believe that recreation provides a very cost-effective intervention strategy that will maintain and/or improve the wellness of many individuals. We're pleased that the district health council and the council on aging also spoke on behalf of the role of recreation in long-term care.

(4) The last thing we'd like to mention is that we also think that recreation may reduce the amount of medical interventions now required in support of the quality of life for the client. If we can prevent some medical interventions, we'll save the system a little bit of money.

**The Chair:** I think probably all members of the committee by the end of the week sometimes feel that they're about to enter the disability zone and we probably should have had you lead us in—

**Mr Sparling:** It may be an occupational hazard.

**The Chair:** —some weight lifting or how to sit in our chairs in a more effective way. That being said, Mr Wilson.

**Mr Jim Wilson:** Thank you for your presentation. Some of the points that you make are very similar to those that were made by the council on aging earlier this afternoon. I'm just going to ask you very pointedly: Do you know how you fit in to the MSAs and the basket of services right now? Has anyone consulted with you, because we look at professional services, we have physiotherapy and occupational therapy and we've had some discussion about rehabilitation services, but none specifically about recreational and what should we be putting in there to make sure that your profession's not left out.

**Mr Sparling:** That's a very good question. Lindsay, anything to say?

**Ms Webber:** One thing that is really missing out in the community now is sort of a community recreation therapist or recreationalist, or however we've been termed. Working in the hospital, one big role of mine working with outpatients is getting them involved in community programs, but that sometimes just goes to a certain point. With OT and physio and dietary and nursing, a lot of people can be staying in the community and can be headed off before having to come into an institution or a facility for treatment. There's no such thing out there and that's, I think, something that's going to be very important, especially to keep people in their homes.

One thing with the healthy neighbourhood program, the public health nurses are trying to get people out into the community and neighbours helping neighbours, but there's no one to help these frail, lonely, isolated people to get out into the community, and where are they going to go?

**Mr Jim Wilson:** I was thinking you play a particularly important role in combating loneliness because, to me, I spent two evenings recently at Toronto Hospital emergency department and the prediction is after 11 o'clock at night, the physicians told me, you're going to see elderly people come in and there's nothing wrong with them medically but they're lonely, they can't sleep. Sure enough, on both nights, I think we had a total of about six, and it's enough to keep you busy because they all have to be checked and that. In chatting with them, they just had nothing to do. They're at home, they're doing what the government tells them to do, but they're going out of their minds with loneliness.

**Ms Webber:** For a lot of the seniors, their big social

contact all week is the VON that gives them the bath, the homemaker that comes in and cleans their house, the person from Meals on Wheels that drops off their meals either once a week or once a day, and maybe the mailman, and they look forward to that.

**Mr Jim Wilson:** And the MPP every four years.

**Ms Webber:** Yes. And that's it, unless they're linked up into something.

**Mr Jim Wilson:** Right.

1700

**Mr Sparling:** The linkage, I think, is critical because what's happened certainly in Ottawa-Carleton is that there are substantial programs for the independent elderly, for seniors, and that's wonderful because hopefully those people will never be part of the long-term care system.

I think that's a possibility, that that will occur, but one of the reasons we're here is that we had the sense that no one was speaking for recreation, that no one had been asked, and to be honest, we're getting sort of tired of it. We were getting kicked in the shins out there and we'd like to say something every now and again.

**The Chair:** You have, I think, brought a perspective on this that we've seen before but not to the extent that you've presented today. We want to thank the three of you for coming to committee.

**Mrs O'Neill:** Mr Chairman, I wonder if I can make a request we've made before in this committee. We've made a request for the draft regulations for Bill 173. I wonder, had that come up again today with these presenters? We've now had a two-week break on hearings. Is there any hope of us getting any draft of regulations around 173?

**The Chair:** Beyond, you mean, the regulations we received before.

**Mrs O'Neill:** The regulations we received, as I've examined them closely, are the regulations to Bill 101. They are not the regulations to 173. I didn't have time to examine them the day we got them, and I've been quite disappointed by that.

**The Chair:** Okay, the parliamentary assistant and then we must move on.

**Mr Wessinger:** I think it should be understood with respect to regulations under an act, they are not worked on or even prepared until the act is completed. So there are no draft regulations that exist under Bill 173.

#### ONTARIO HOME CARE CASE MANAGERS' ASSOCIATION, EASTERN REGION

**The Chair:** I call the Ontario Home Care Case Managers' Association, eastern region.

**Ms Judi Burke:** I'm Judi Burke and this is Susan McGurn. I want to thank you, Mr Chairman, and committee members and ladies and gentlemen. The eastern region of the Ontario Home Care Case Managers' Association—

*Interjections.*

**The Chair:** Order. Sorry, order. Members of the committee, hey, order. I appreciate—order, Mr Martin—we're at the end of a long afternoon, but I would request that we respect the presentations that are being made. We

can have our arguments in the Legislature and in the corridors, but we're here to hear from the presenters.

**Ms Burke:** The eastern region of the Ontario Home Care Case Managers' Association includes case managers who are employed in six of the province's 38 home care programs. These programs are Kingston, Renfrew, Leeds-Grenville-Lanark, eastern Ontario, Ottawa-Carleton and Hastings-Prince Edward county.

Susan and I are pleased to present our views on Bill 173 to this committee on behalf of our members in these areas, although I understand from Susan that in Kingston, I guess it's tomorrow, Leeds-Grenville-Lanark case managers are also making another presentation.

This very important bill will not only reshape the long-term care delivery system in this province, but it will affect all of our lives in some significant way, whether we are consumers, family members, care givers or professionals working in this province's health care system. As responsible professionals with extensive experience in community-based care, we welcome reforms that will improve services to Ontario's consumers.

Our brief will have a bit of a different focus from the response by our association executive in Toronto, but we want to just repeat that we strongly endorse the Ministry of Health's long-term care reform objectives. I think you've got them all in the copy of the brief here: easier access to long-term care services; consumer participation in the planning process; a consumer bill of rights and appeal process; the integration of community services, thus addressing fragmentation and duplication in service delivery; and local planning by district health councils to accommodate the regional differences.

The purpose of this brief is to talk about case management and case managers. We haven't seen anything about case management in the bill, and that's what our concern is. I may be needing to get reading glasses, but I haven't seen anything that is listed in the bill. We prepared this response to show that case management and the skill of case managers in the home care program is an essential part of Ontario's new long-term care system, and we'd like to point out the need to include case management in Bill 173.

I've chosen to quote Carol Austin in her article "Case Management in Long-Term Care, Options and Opportunities," because she is the chairperson of the International Conference on Case Management, which will be held in Toronto next weekend. Carol, from her article "Case Management in Long-Term Care, Options and Opportunities," describes case management in this way:

"Case management is widely viewed as a mechanism for linking and coordinating segments of a service delivery system within a single agency or involving several service providers to ensure the most comprehensive program for meeting an individual client's needs for care."

Carol goes on to say:

"The principle functions of case management in long-term care are the following: (1) screening and determining eligibility; (2) assessing the need for services and related needs; (3) care planning, developing a service

plan; (4) requisitioning services; (5) implementing the service plan, coordination service delivery and follow-up; (6) reassessing, monitoring and evaluating services periodically."

All of these functions are performed by case managers in the eastern Ontario region as well as throughout the province. Case managers do this not in isolation; they do it in partnership with community service providers and with community support services. In this way we can keep a balance between quality service and fiscal responsibility.

Principles of case management can be taught in a university or learned from a textbook, but good case management is learned in the field doing case management. In Ontario case management is not about managing people. It's about assuring quality community care to meet the needs of people.

The approximately 200 full- and part-time case managers employed in the eastern region have extensive job experience in hospital and community nursing and other health-related disciplines; 65% of these case managers have baccalaureate degrees, and they have all developed comprehensive assessment skills and expertise in the design of service plans. These service plans address with our clients the issues of wellness, rehabilitation, reactivation and prevention.

Susan and I have a combined community experience of over 26 years. Both of us have worked in all the specialty areas of home care, palliative care, school services, seniors case loads, hospitals. I guess I'd like to talk a little bit about our consumers here, because we don't seem to feel that the people at the ministry have a grasp of the kind of consumers that we're working with.

Today the consumers that are being serviced by the home care program have many and complex needs. Most are vulnerable and over the age of 75 and with limited personal support and cognitive impairment. Others are at home because of improved technology, and the improved technology has made it possible for them to be there. We have people that are respirator dependent, and they're able to be managed at home with support from specialized services and specialized equipment.

This particular group of people require more than just service coordination, which is discussed in the bill. Case managers with these kinds of clients assist the consumer to negotiate the system by explaining and interpreting services and interpreting the use of the services. Not everybody understands what an occupational therapist is. Not everybody understands what a nutritionist can do for them at home. Also there are many people out there who just have a great deal of difficulty accepting help from a stranger and someone coming into their own home.

We provide advice to the consumer and his family in time of crisis and we also provide them with the support and counselling. We also make available information regarding respite care and placement so that they can make wise decisions about these things. A lot of people who are considering placement after being informed about the costs and the process change their minds, especially when they realize that we can provide them with support services at home.

## 1710

Another thing that we are involved in as case managers is adjusting the volume and the type of services, because needs change frequently with this group. Someone in one week may have a fall and go to hospital and require extra services, because the hospitals aren't keeping people any more. When they go into emergency, they're sent back home to manage at home with support services.

In order to make our job possible, we work in partnership, as I said, with service providers to assure that these changing needs are met. In the previous presentation they mentioned something about linking with recreation services. That's one of the things that we do with our lonely and isolated clients. We link them up with day care programs and any other recreation services available in the community.

My next statement says that every case manager in Ontario can give you examples of what good case management can accomplish. But we've decided instead to have Susan do a little visualization, because I think her visualization will give you a good idea of what case management is all about.

**Ms Susan McGurn:** I'm sure that over the duration of your hearings you've had lots of examples of clients who are seen by the various groups in the community, and I'm sure that you've had lots of descriptions of clients. I was recently approached, related to long-term care and to Karen Goldenberg's activities around MSA development, to put together something of what I saw happening. I guess my biggest concern—I am an acting manager at the moment, but in normal practice I practise as a case manager, and what I was seeing was an oversimplification of the consumers, and not just the consumers, but of the service itself and the service delivery system.

We have, in health care, started describing clients as being on a continuum of health; they're either further up or further down the continuum than other people out there. That's true in one way, but it really does oversimplify the consumer we are dealing with. Because of a historical perspective in our own program in Kingston, I tried to visualize, and I'd like all of you to do this, the clients, the consumers, those people out in the public accessing the service—and this can be yourself as well—as a quilt. Your life experiences are all the patches that make up that quilt. Nobody's quilt is exactly the same. We come from different educational backgrounds, different work backgrounds, different monetary backgrounds, we have different family and friend supports, and that's the patchwork that makes up our life experience.

What happens when there is a crisis in our life, be that an unexpected death, a change in our physical health, a change in our mental health, a change in our finances, is that either a patch wears thin, the patch rips or the stitching comes out. It's really easy to visualize what happens to people's lives. For instance, if the stitching comes out, not only does the crisis that happened affect us, but all of those squares around the crisis are affected. That may mean that family and friends are affected, it may be that our jobs are affected, it may be that our

finances are affected. By simply putting a consumer on a continuum of health, we negate a lot of that and really oversimplify the effect that the health crisis or the change in our life can have on us as individuals and as caregivers of those individuals. Even recently, in the AIDS report that was forwarded to our local program, there was a documented note that in times of crisis and health stress, the last thing you wanted to be doing was trying to sort your way through the system.

What I'd like to reflect on in the context of the quilt is that there are a few things that make up a quilt. One is the backing, and the backing represents the different ministerial guidelines, programs and volunteer organizations that are out there. The other part is the patches themselves, and I don't mean the patches in a derogatory manner. Reflecting on our grandmother's quilt lying at the foot of the bed, those patches are made up of a wedding dress, an important suit, a tie, your daughter's dress for her christening. They're very important, and it's the fabric of those squares that makes up the fabric of the organizations that we're in touch with in long-term care delivery, be that VON, volunteer organizations, individual boards of health etc. We have a fabric and it's very important, because we've come from a history that's important to be maintained.

The other buzzword that goes along with long-term care is "seamless." For any of you who sew—I don't, but I did learn this while working on this—there's no such thing as a seamless piece of material. Seamlessness does not exist. Seamlessness comes from very close stitchwork, networking those patches together.

What I offer you is that a case manager works from a pile of those very unique patches—not rags, but rich remembrances of our past—and helps sort, with a client, the appropriate patches and helps to sew them into their service care. What you end up with then is a security blanket. If the ministry refuses to recognize the historical perspective and the very good things that have come out of our programs throughout the province, what we will be asked to settle for is a cheap imitation rather than an heirloom.

My comments are not included in our brief simply because it's very hard to visualize them on paper. I hope that has presented what I feel case management is, that it's the needle that helps sew in those patches and helps sort through all of the patches out there to come up with the most appropriate quilt of care that provides security to the consumer and the public.

**Ms Burke:** Okay, how does everybody feel? Do you like the quilt?

Just to summarize, the needs and rights and choices of consumers have always been the primary focus of the home care case manager. I'm sure this is important to the consumer, and any one of the people we work with in the community will be able to tell you that. Consumers in the current home care system have complex and changing needs. They require direction and support from an experienced professional.

I just came from a visit today with a lady and her husband, both of them not in good condition at all, and she was told on the phone while I was there that the

cancer had spread to her liver. In this kind of situation, I was glad I was there at the time, because I was able to help them to decide what kind of help they needed and where they wanted to go with any of this and to give both of them a little bit of support. They had never had access to community care services in the past.

Functions of screening, assessment, service planning and coordination, which are presently being done by home care case managers, will certainly continue to be needed in the new system. I don't know who the ministry has identified to take on these tasks, but I feel that case managers who have accumulated the years of experience in performing these functions are probably the most appropriate people to carry on. Transition to an integrated system will require case managers' experience and skills to assure that consumer needs are met and quality and accountability are not compromised.

New legislation will allow for more flexibility in services and eligibility. It sounds like we're going to be able to provide any frequency of service and that eligibility criteria, because we have such a basket of services, will be opened more than they are now and there won't be so many regulations. We like that idea, because we have a lot of consumers whom we work with who probably would benefit from different kinds of services but less of each. A skilled assessor will certainly be needed to assure, again, the appropriate allocation of resources.

Finally, we want to recommend that consumers requiring long-term care continue to be assured access to a professional experienced in comprehensive assessment and service planning to assist them in making informed and appropriate choices.

We want to ask that the new system be built on the strengths of the current system and avoid the startup costs incurred when major restructuring is done.

We recommend that the expertise of the home care case managers in screening, assessment, service planning and coordination and their sense of fiscal responsibility be recognized and the need to maintain this expertise in the new delivery system be acknowledged.

#### 1720

We recommend that a research component be built into the new system to evaluate the system, the services and the consumer outcomes. We want to know the value of our services and how they work and whether or not we're achieving the goals that we set out to achieve with our clients.

Finally, during my 14 years as a case manager with home care, and I had seven years before that with social services, I've talked with many peers. Since I've become the membership secretary for the Ontario Home Care Case Managers' Association, I've had the opportunity to network with case managers all over the province. My experience has been that these are very committed professionals. They want to ensure that Ontario consumers receive the right service at the right time in the right place.

That came from a video. I don't know if anybody's had a chance to see it, but it's about the quick response

team in Victoria. Looking at the video, I saw a lot of the kinds of things that we are already doing here in Ontario through case management.

As the members of this committee review the input from the hearings and the briefs and as you formulate your recommendations, we urge you to include case management in Bill 173 as a professional service and core function of the new MSA. This decision will ensure continued excellence and caring as well as accountability in Ontario's new community-based long-term care system.

**Mr O'Connor:** Thank you very much for your presentation. One thing I think that has been pointed out to us is the important need for taking into consideration what we have out there and building on all the excellent pluses that we have. Right in your beginning you said that we should use the extensive experience that's out there right now. I think that's what we want to do. When we get to the regulation point, we don't want to overlook anything that has been presented to us, but make sure that we can use that as well.

One of the things that came up this morning by one of the presentations, and I'll just maybe just ask you for a reaction to it, and we've heard it a couple of times presented to us, is that in the assessment of the needs of the consumer we don't want to focus on just the medical needs. Listening to what you've suggested here, it doesn't look like you look at only the medical needs, but I wondered if you could maybe give us some reassurance or give us some practical experiences that you do have about how we're not focusing on only a medical assessment here.

**Ms McGurn:** I can speak for the program that I work in. I happen to have started an orientation group this morning. Our policy and procedure manual is probably your first reassurance.

If a client is referred to the program, be it through their family physician with a medical referral or by a simple telephone call, family calling in wanting to know about services, if it's hard to get a handle on over the phone, our front-line defence is to send a case manager in to see that client. If we get in there and their need is not medically related, we don't go, "I'm sorry, our services aren't for you," and walk out the door. Right included in our policy manual is that a front-line responsibility of the case manager is to explore both the physical, emotional, social and recreational situations of that client, not just in isolation, but in the context of their family, their friends and their neighbourhood, because as we know, many of the communities we service offer different supports.

Our job if they're not eligible for service is to help them link with the appropriate services. For some consumers, that means simply providing them with the information. For other consumers it's walking with them through the corridors that take them to those services. Our job is not simply to determine eligibility of the ministry criteria for home care.

**The Chair:** We're caught in the time bind, but I want to thank you very much for coming before the committee and again for the quilt that you have left with us.

**Mrs Sullivan:** I wonder if we could ask the parliamentary assistant if the government has considered the argument of the case managers. We've indicated that we would put forward an amendment to include case management as a professional service. The government said that it was going to think about that. I wonder what its conclusion was.

**The Chair:** Briefly if we could, because we are well behind time.

**Mr Wessenger:** I certainly think the position that was put forward was that the case management function is defined in, I believe, section 20 of the bill. Therefore, that function was clearly set out in the act, and it certainly is considered a key aspect of the long-term care system.

CANADIAN RED CROSS SOCIETY.  
ONTARIO DIVISION, OTTAWA-CARLETON BRANCH  
SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE,  
DIVISION DE L'ONTARIO,  
SECTION D'OTTAWA-CARLETON

**The Chair:** I call on the Canadian Red Cross Society, Ottawa branch. And to give hope to the Senior Citizens' Consumer Alliance for Long-Term Care Reform, we're almost with you.

Welcome to the committee. I again apologize. It is late in the day, but we appreciate very much that you have stayed with us and are here.

**Ms Jane Levo:** I should indicate that Vera Lee Nelson, one of our senior volunteers, was to do the presentation. Vera Lee is a long-distance care giver and has had an emergency with one of her parents and has had to fly out to provide some assistance, so you're going to have to put up with me. I do ask you to bear with us. My name is Jane Levo and I'm the manager for the homemaker service for Renfrew North.

I would like to introduce Madeleine Germain-Kennedy, who is from the Cornwall area and will be speaking after I complete my portion. I know it's been a long day, and maybe we can look on this as a benefit because you don't have to listen to the portion that Vera Lee was going to do. You have it in writing, and I really couldn't do it justice. So you get a break late in the day.

The Ottawa-Carleton branch of the Red Cross is one of the oldest branches of the society in Canada. This year it celebrates its 80th birthday, and we're proud to have provided services to our community since the early 1900s. Until 1914 we actually weren't the Canadian Red Cross, but rather provided services under the British Red Cross, and an act in Parliament then created the Canadian Red Cross. We do get acts through once in a while.

The eastern region of the Ontario division of Red Cross consists of 12 branches, and geographically the area that we provide services in is bounded by the Ottawa River and the St Lawrence River on the north and south, Algonquin Park to the west and the Quebec border on the east.

The Red Cross provides services in both official languages. The area of Prescott-Russell is one of the largest areas of French-language concentration in the province. We also provide service to the largest Polish

population outside of Poland and we do provide services in Polish in that area as well. Red Cross provides services to the Algonquin first nations at Golden Lake and to the Mohawk Council at Akwesasne. Examples of services that we provide to these first nation people are home-making and train-the-trainer components for child care and first aid, and emergency support is provided to a residence for seniors. Where possible, we recruit staff from the communities in which we provide service and therefore try very hard to reflect the language and cultural needs of these communities.

Red Cross is an integral part of all of our communities. We have a long history of compassionate, effective and efficient services throughout the world. We always respond when possible and when help is needed.

Local Red Cross support services include a variety of home support programs and homemaking services.

**1730**

For the purposes of this presentation, we would like to concentrate on the statistical information for the areas that we specifically serve in this part of eastern Ontario, which include Renfrew county, Ottawa-Carleton and the five most eastern counties. These community services are provided through the efforts of over 1,300 volunteers and 600 staff, and the vast majority of these volunteers and staff are women and trained home support workers or homemakers.

Madeleine, maybe you would like to briefly describe some of the implications of the reform.

**M<sup>me</sup> Madeleine Germain-Kennedy :** Merci, Jane. Monsieur le Président, distingués membres du comité, maintenant c'est à mon tour de vous adresser la parole dans la langue de Molière.

Mon nom est Madeleine Germain-Kennedy. Je dois vous dire que je suis très familière avec la Croix-Rouge de Cornwall et la région ainsi qu'avec les services qu'elle offre.

Ayant été très impliquée dans la communauté à Cornwall et les environs, à titre de bénévole, professeure, membre de divers comités hospitaliers, journaliste, reporter, commentatrice à la radio française, et j'en passe pour le moment, j'ai très souvent eu du contact avec la Croix-Rouge de Cornwall. Je parle donc en connaissance de cause. De plus, en 1985, j'ai appris que je souffrais de la sclérose en plaques, aussi connue sous SP, ou MS en anglais, multiple sclerosis. Mon médecin m'a donc référée à la Croix-Rouge de Cornwall afin d'obtenir les services d'une auxiliaire familiale.

J'ai été des plus fortunés d'avoir à mon domicile les services compétents et fiables d'une auxiliaire familiale de la Croix-Rouge alors que ma santé était des plus fébriles à ce moment-là. Quel avantage d'avoir dans son domicile une telle perle, une perle de la Croix-Rouge. Au cours des prochaines minutes, je vais vous offrir quelques commentaires sur la réforme.

La division de l'Ontario de la Société canadienne de la Croix-Rouge appuie les efforts du gouvernement dans sa réforme des soins de longue durée. Nous soutenons vivement les principes et buts décrits dans Partenariats dans les soins de longue durée : Un nouveau moyen de

planifier, d'administrer et d'offrir des services et du soutien communautaire. Ces principes et objectifs ont été identifiés lors d'une consultation de grande envergure avec des participants clés, processus auquel la Croix-Rouge était fière de participer.

Cependant, quelques sections de l'ébauche du projet de loi 173, une loi concernant les soins de longue durée, ne reflètent pas les principes formulés et qui nous affectent. Nous croyons vivement que cette loi doit être une loi évolutive et non normative. Une loi évolutive pourra être adaptée dans un avenir lointain. Lorsqu'une législation contient trop de détails, elle devient rigide. La législation doit être plutôt flexible si elle veut résister aux changements rapides des soins de longue durée et si elle veut permettre aux fournisseurs de services de répondre aux besoins changeants de leur communauté. Une loi évolutive est essentielle si tous les partenaires impliqués dans les soins communautaires de longue durée sont prêts à mettre sur pied de nouvelles structures et des processus innovateurs qui déboucheront sur une véritable collaboration et une chaîne de services efficacement fournis.

De plus, nous recommandons que la législation respecte les principes et les traditions des agences bénévoles qui offrent des services communautaires de soins de longue durée. Ces agences sont bien enracinées dans leur communauté. Un grand nombre de services offerts ont été développés en réponse à des soins uniques de la communauté. Ces services ont été mis sur pied par des membres dévoués et aussi visionnaires qui ont choisi de donner de leur temps et de leur argent pour répondre aux besoins de leur communauté. Il serait donc impossible d'en évaluer le nombre d'heures.

On réfère souvent aux lettres OSP. Ces trois lettres veulent donc dire organisme de services polyvalents. La législation telle que présentement élaborée empêche la Croix-Rouge, ses régions, ses sections ou encore ses programmes de devenir un OSP ou de fournir des services comme membre d'un OSP. Malgré cela, la Croix-Rouge s'est engagée, sur la base de services développée au cours des 75 derniers ans, à subvenir aux besoins des personnes les plus vulnérables dans notre communauté.

La division de l'Ontario de la Société canadienne de la Croix-Rouge n'est pas une organisation distincte de cette dernière, mais est une partie intégrante de cette entité corporative nationale qu'est la Société canadienne de la Croix-Rouge. Celle-ci se greffe, à son tour, au Mouvement international de la Croix-Rouge et du Croissant Rouge. La Croix-Rouge a, derrière elle, une longue histoire de services mondiaux efficaces.

Et remarquez bien : il ne peut y avoir qu'une seule Société de la Croix-Rouge dans un même pays. Nous travaillons selon les règlements établis par la Société. Ces règlements décrivent les structures de commandement et les structures organisationnelles et définissent nos champs d'opérations. La Société est donc coiffée d'un seul conseil d'administration qui est le grand responsable de l'ensemble des directives et des opérations de toutes les composantes de la Société. On ne peut accepter d'entente ou de consensus qui pourrait diminuer l'autorité du conseil de la Société ou même affaiblir ses principes fondamentaux, particulièrement l'indépendance et l'unité.

La législation requiert que chaque OSP soit incorporé sous la loi des corporations de l'Ontario ou la loi des corporations coopératives de l'Ontario. Chaque OSP doit avoir son propre conseil d'administration choisi en fonction de la loi. Ces prérequis sont incompatibles avec les principes fondamentaux et la structure corporative de la Société de la Croix-Rouge.

Je vous remercie de votre attention. Maintenant, pour le mot de la fin, cette fois dans la langue de Shakespeare, de retour à Jane.

**Ms Levoy:** I'd like to make some specific comments on Bill 173. There are several issues that are of particular interest or concern to us that we would like to highlight in this presentation.

The Red Cross recommends that three sections of the legislation be amended. Our specific recommendations have been previously described to the standing committee. We believe that these amendments would in no way adversely affect the purposes of the act. Rather, they would enhance flexibility and allow communities to build on the existing strengths of the system.

Our first concern is that the bill describes four categories of service and specifically delineates the services that fall under each category. The basic premise underlying the breakdown appears to be the separate personal care, or hands-on care of the person, versus non-personal care and services. We have two concerns with this aspect of the legislation.

The division between homemaking and personal support services is inconsistent with current practices and the emerging future trends. This program is intended to produce a worker trained to take on a role that goes beyond the current role of the homemaker. A curriculum is close to being finalized and at one point it was expected that the program would be introduced this year.

The separation of personal care versus non-personal care and services appears to be impractical and may create serious difficulties for the management of service delivery. Many functions routinely provided by homemakers cross the boundaries between what the legislation classifies as homemaker and what's called personal support.

We are also very concerned that the uncertainties arising from the reform have created significant anxiety among our staff, and one of our highest priorities is to look after the interests of over 6,000 individuals, mostly women, whom we employ.

#### 1740

Our second concern is that the bill stipulates an MSA may not spend more than 20% of its budget to purchase community services. The Red Cross recognizes that the government has committed to moving away from the brokerage system. In our opinion, the problem with the current delivery system is not brokerage but the lack of coordination and poor access.

Presently, many services are provided effectively and efficiently by a number of established agencies. These agencies have long histories of service to their communities. They are often supported and governed by volunteers who are part of the community. Stable relationships

have been developed between provider agencies, care givers and the individuals they serve. Let's learn from our experiences and work to fix the shortcomings of the existing system rather than jump into a totally new and totally unproven system.

In many communities, services are provided by several provider agencies. Each agency must retain a critical volume of service to remain economically viable. If the volume of services falls below this critical volume, the agency will not be able to stay in business. The Red Cross is very concerned that the legislation may result in waiting lists, a decline in the quality of service or limited or no choice of services. Those clients who wish to purchase services outside of the MSA system will be unable to do so if there are no alternative providers remaining in the community.

In many areas of the region it is very expensive to provide services. The entire region experiences an ongoing deficit, primarily due to the high cost of getting homemakers to the homes of those clients who live in remote areas. In some communities the Red Cross is the sole provider of services, and I know that in Renfrew county we have two areas where the Red Cross is the sole provider of service. In all of Renfrew county, for example, the population density is 11 people per square kilometre, with our largest serving centre being Pembroke, and it has a population under 13,000. One of our communities, Bissett Creek, enhances another problem. All of the people who live in that community are retired. It's difficult to hire employees in isolated communities when everyone's retired.

Given the factors we have just described, and combined with an inequitable bill rate for services, Red Cross depends on its province-wide structure to give it the flexibility to fund services in many areas where deficits are the norm, and the deficit in eastern Ontario for homemaking services likely will approach \$700,000 to those members of our communities who may not get services through Red Cross if we weren't being funded from other programs within the province in Red Cross.

Our third concern is that the legislation says that MSAs have just four years to comply with all the provisions of the act. Under tight strictures of this draft legislation, communities will not have the flexibility to identify and implement the models of service delivery that suit their needs best. Red Cross is a volunteer-based organization. Our wide range of programs and services provide volunteers with diverse backgrounds and interests, with a variety of meaningful opportunities to participate in the work of the society. Our quality service comes from the partnership between volunteers and staff who are committed to our vision, the mission and our fundamental principles.

We're also concerned because we believe that the creation of an MSA will impact severely on our volunteerism. MSAs could be perceived as very impersonal agencies that many will continue to perceive as quasi-governmental. The fellowship and sense of community contribution that motivate most volunteers often depend on local agencies which have a long, well-established tradition and that provide a sense of companionship and

responsiveness to local needs. We feel the legislation will have a very damaging impact on the role of the 1,300 volunteers within the eastern region of Red Cross.

We are very concerned about the enormity of the impact of this legislation if it has not been fully explained to consumers. Government speaks of expanding services to underserved areas, yet there will be few additional resources made available. Clients are unaware of the impact that this legislation will have on agencies that have been providing services to them over the past several decades. The legislation must permit agencies such as the Red Cross to continue to provide necessary services to the residents of the province. However, if the legislation is to be proclaimed without the amendment, the Red Cross and many similar agencies will be forced out of business. If this is to be the case, then the government has an obligation to inform the public.

Thank you very much for the opportunity to address you.

**The Chair:** Thank you very much. I'm sorry, because of the hour, we are not going to be able to move into questions because we do have another presenter. We have to start again at 7 o'clock and I want to make sure these folks are still going to be awake.

I could just say that we have, as you know, had presentations from a number of the Red Cross societies and, as you indicated, the specific recommendations the committee is aware of, and we thank you for those. I think I should say too, on behalf of all of those who are trying to improve their French, that we really appreciated the way in which you presented that part of the submission. I think everybody felt, "Aha, I'm really making progress." Alors, merci beaucoup.

**M<sup>me</sup> Germain-Kennedy :** Ça m'a fait plaisir.

**The Chair:** Thank you both again for coming before the committee.

SENIOR CITIZENS' CONSUMER ALLIANCE FOR  
LONG-TERM CARE REFORM, OTTAWA BRANCH

**The Chair:** I call on the Senior Citizens' Consumer Alliance for Long-Term Care Reform, Ottawa branch. Mr Hanmer, you've been very faithful at the back and we do welcome you and appreciate that you've taken the time to prepare the submission and come before us.

**Mr Bert Hanmer:** Mr Chairman, ladies and gentlemen, there's an old saw which says, "The head can absorb just as much as the seat can stand." I hope your seats can stand a little more.

My name is Bert Hanmer, a resident of Ottawa-Carleton for 43 years. Since I retired in 1980, on reaching statutory retirement age, I have worked as a senior volunteer in various programs and projects locally, provincially and nationally.

I think a word of explanation is desirable at this point. I find myself faced with a somewhat anomalous position in that I was asked to submit a supplementary brief to the main brief of the alliance before the main brief itself had been presented. It's to come up on Thursday.

**Ms Gigantes:** It's called an appetizer.

**Mr Hanmer:** That's right. I have therefore decided to put forward a number of issues which have been the

subject of discussion among seniors in this community as far as MSAs are concerned. So much by way of explanation.

I have kept in touch with developments in long-term care for many years under successive Conservative, Liberal and NDP provincial governments. The formation of the Senior Citizens' Consumer Alliance for Long-Term Care Reform was a really progressive step in tackling this issue which is so important to seniors. Three major provincial groups came together in 1991 to form the alliance. Collectively, they represent approximately one million individuals. They have held lengthy public hearings, held policy conferences bringing consumers, providers and government officials together, and have compiled two substantial volumes on LTC reform that were distributed province-wide. As I indicated earlier, they'll be presenting the main brief on Thursday in Toronto.

As a senior citizen of long standing and a member of the United Senior Citizens of Ontario, I support the alliance's endorsement of the multiservice agency concept. It is an efficient and effective way of organizing community care.

I will try not to pre-empt what Mrs Jane Leitch, the alliance's chairman, may say on Thursday. I will therefore deal with comments, as I mentioned earlier, that have been raised by senior consumers in this area.

Concern and apprehension: These are testing times for senior citizens. There have been cuts in the scope of the drug program; the property tax grant has been revamped; the government of Canada introduced the clawback of old age security and amended the Income Tax Act as it affects the age credit. If we are to believe the media, extensive changes affecting eligibility to the old age security pension are in the offing. There is concern and apprehension as to what the future holds.

Change is worrisome to many people, particularly the aged sector of our population, and at the moment long-term care poses a new potential source of worry. Much of this concern arises from a lack of knowledge about the true nature of MSAs. Seniors simply do not know what it's all about. The situation is aggravated by individuals who, for reasons of their own, would prefer the status quo and who portray the proposed reform in negative terms.

1750

It has also been suggested to me that the present is not the time to try out what is described as a radically new approach. This is nonsense. The province of Quebec has had in operation what are known as CLSCs, Centre local de services communautaires, for about 20 years. Though not identical to the proposed MSAs, they're very similar. Inquiries reveal that though there were a few teething troubles in the early days, CLSCs have been a valuable part of care in Quebec for years. The system is based on one which proved itself in Switzerland.

Initially, CLSCs did not operate on weekends, but a seven-day-a-week operation was found to be essential. This question may well be important in the planning of the MSA program. Lack of Saturday and Sunday service

is a problem which currently exists. It should be remedied when MSAs are established, even though it would clearly add to the cost.

A comprehensive education and information program is essential so that seniors and others may be reassured that the proposed new service is one of proven value and not just an experimental project.

**Volunteers:** A great many devoted senior volunteers are involved in community support programs for their peers and for persons who are not seniors. Concern has been expressed that the introduction of MSAs would result in reduced participation by volunteers in community care programs. The seniors' consumer alliance disagrees with this view, and I concur, bearing in mind the high degree of community participation inherent in the MSA proposals. One step that might reassure volunteers that their involvement in the task of their choice will continue would be to ensure their inclusion, together with consumers, on MSA boards.

In the same vein, fund-raisers, many of whom are senior volunteers, are concerned that the establishment of MSAs may inhibit their fund-raising efforts in the future. I do not believe that this will happen. Again, a process of educating those involved will allay concerns.

Steps should also be taken in those communities where the United Way is established to ensure the fullest degree of liaison with that fund-raising organization.

**Amendments to the Health Insurance Act:** The seniors' consumer alliance has expressed satisfaction that the home care program, through a provision in Bill 173 to amend the Health Insurance Act, will become part of MSAs. A less satisfactory aspect of the proposed legislation is that a client of a home care program will not be automatically covered by OHIP under Bill 173. This is because eligibility criteria will be defined in the regulations. Failure to guarantee protection in the act will seriously undermine efforts to promote care in the home as against care in an institution.

**Funding:** One of the primary objectives of long-term care reform is the integration of a range of community services. Another is to provide assurance that local needs can best be met by a substantial element of local autonomy. The alliance believes that there should be global funding of MSAs. Without such funding, it will not be possible to achieve a truly seamless system of community services.

I might interject here that I had an experience a few years ago in the province of Manitoba, where I was spending a little time, to look into the global funding of certain large community projects providing housing, hostel care, nursing home care and a very large day centre providing home care and with an extension to the community. They had, the year before, been put on a global budget, and it was proving to be tremendously advantageous to them because if they were up here and down there, they could make the adjustments without having in every case to refer back to the original funder.

For example, if an MSA had a waiting list for some services and a lack of demand in others, the board must be able to transfer dollars from one program to another.

If the draft legislation does not change, global funding may be impossible. For example, the 20% limit on the purchase of service from independent service providers would negate, in some situations, the ability of an MSA board to take full advantage of global or per capita funding.

**Limits on the purchase of service:** There is another aspect of the 20% limit on the purchase of service. It is that in communities such as Ottawa-Carleton, where the level of services is already high compared to some other areas, the limitation may well disrupt achieved levels of service. The inclusion of recreational and other like services could further exacerbate the problem. There would appear to be a strong case for greater flexibility in this regard.

As indicated at the outset, this presentation does not purport to refer to all important issues of concern to senior consumers. The seniors' consumer alliance brief will deal with many of these. Today's submission is intended to demonstrate that the alliance has support in this part of Ontario. We also believe that we can offer comment, for example our reference to the Quebec system, which may make a small contribution to LTC reform and result in action to reassure senior citizens as to the future.

Thank you for the opportunity to appear before you.

**The Chair:** I think it's appropriate that the last witness this afternoon should be someone who is a consumer and a senior. We thank you very much for the comments you've raised here which will no doubt help us when we meet with the alliance in Toronto on Thursday.

Members of the committee, we stand adjourned until 7 o'clock sharp.

*The committee recessed from 1757 to 1902.*

#### ONTARIO COMMUNITY SUPPORT ASSOCIATION, AREA 10

**The Chair:** We'll start this evening's presentations, of which we have four. The first presenters are representing the Ontario Community Support Association, area 10. Welcome to the committee. We are refreshed, and glad you could come before us. We have a copy of your submission, so if you'd just introduce yourselves, please go ahead.

**Ms Janet Snyder:** Good evening. I'm Janet Snyder, and with me this evening are Ann Hargest of the Visiting Homemakers Association of Ottawa-Carleton, and Nancy Wilson of Good Companions Seniors Centre in Ottawa.

We are here to represent the concerns of the 51 member agencies of area 10 of the Ontario Community Support Association. This area coincides with that of the long-term care area planning office and includes Renfrew, the regional municipality of Ottawa-Carleton, and the five counties of Prescott, Russell, Stormont, Dundas and Glengarry.

We realize that you have already heard the Ontario Community Support Association response to Bill 173 and have received its written submission. This presentation will not repeat that provincial response but will focus on area 10 concerns.

The agencies we represent deliver services to the frail

elderly, persons with a disability, and those convalescing from an illness. The services provided assist individuals to live independently and maintain their health at home.

Area 10 member agencies provide services in both rural and urban settings. Services are provided by bilingual and by francophone agencies in many regions. Partnerships with several ethnic communities have been formed to assist them in providing culturally appropriate services.

Community support agencies are volunteer-driven and supported by staff. Most community support services, with the exception of homemaking, have a large number of volunteers with a small number of staff managing the programs.

The staff working in community support services come from a variety of backgrounds, thus providing a multidisciplinary approach to service delivery and management. For example, in Ottawa-Carleton, program directors include representatives from the fields of social work, nursing, recreation, teaching, dietetics and law.

The services, which were developed in response to individual community needs, differ from agency to agency. This difference is a major strength because it reflects the specific needs of each community.

Today we would like to concentrate on three particular concerns with regard to Bill 173: first, categories of service; second, volunteerism; and third, specific aspects of multiservice agencies.

Under categories of service, it is recommended that:

(1) Community support services, homemaking, personal support services and professional services be combined into a continuum of care. This approach will foster true integration of social and health services.

(2) Provision be made in the legislation to recognize the importance of the role of respite care services.

The concept of the continuum of care is fundamental to the provision of services enabling an individual, couple or family to remain at home as independently as possible despite chronic illness, disability or frailty.

The artificial distinction made separating out four types of service—community support services, homemaking, personal support services and professional support services—ignores, with potentially dangerous consequences, the principle of a flexible continuum of care designed to provide the least intrusive and most cost-effective service.

These distinctions indicate more status for the medical treatment end of the spectrum. The danger is in the emphasis on sickness, not health. We need integration of social and health services, not the separation of the services which are less costly yet immensely effective at keeping people at home even when frail.

The purpose of the long-term care reform as we understand it is to encourage healthy lifestyles and to extend the time where independent living at home is possible with the least cost to the community and the most choice to the consumer. Community services may no longer be available if not nurtured by the system.

The separation between homemaking and personal

support services is particularly inappropriate, as it runs contrary to the recently developed personal support worker course. This course, spearheaded by the long-term care division and supported by the Ontario Community Support Association as well as the Ministry of Colleges and Universities and the Ministry of Skills Development, is designed to produce a generic worker who combines the skills of homemaking and personal care. The purpose is to have only one worker in the home who could provide the range of services needed, from light house-keeping to meal preparation to personal care such as baths and personal grooming.

Respite care: It is in respite care that the artificial nature of this distinction is most obvious. One worker, during the absence of the care giver, provides the full range of care for the individual at home, especially during periods of 12 hours or more. Services required range from preparing and serving meals to looking after the home to personal care, including feeding, bathing and dressing, as well as emotional support and reassurance, especially in the case of the cognitively impaired. There can be no distinction in the range of services required to provide for the safety and comfort of the individual, to say nothing of the peace of mind of the care giver.

## 1910

The second concern is with volunteerism.

It is recommended that volunteer management in regulation 11 be expanded to require the development and implementation of a plan for the recruitment, training, scheduling, supervision, retention, recognition and expense reimbursement of volunteers.

There are two key elements to the issue of volunteerism. The first is the service the volunteers provide, and the second is the resources volunteers contribute.

The services volunteers provide: Volunteerism is an essential component in the delivery of the community-based services. If volunteers did not provide the services, either the services would not be available or costs would increase should paid staff be required to assume the role of volunteers.

Each day throughout our communities volunteers go to work willingly, with a commitment to their clients, to the services they deliver and to the agencies with which they work. The biggest snowstorm of the season doesn't stop the volunteers. Last year during a storm that closed Ottawa schools, the Meals on Wheels volunteers delivered over 500 meals to Ottawa residents. Only four clients were missed. There is no paycheque and no benefit plan to be managed. The volunteers work for many reasons, but the outcome is always the same: a stronger community.

The benefit of the services provided by the volunteers is felt by the clients, by their families and by the professionals who work with them. Volunteers also benefit from the program. Volunteer management researcher Linda Graff, in her publication *Volunteer for the Health of It*, published by Volunteer Ontario Publications, documents the positive impact of volunteering on the health of the individual. Community support agencies facilitate this volunteer process. The same individual may

be a client in one context and then take on the role of a volunteer in another. That individual at the end of the day has a feeling of self-worth, of having contributed to the community.

The resources volunteers contribute: In addition to service delivery, volunteers serve in many other roles. They bring their professional skills and experience to the governance of the agencies and to fund-raising and public relations programs. The donation of these skills to the agencies does not show on the expenditure side of the balance sheet but has a significant impact on the revenue side. Volunteers, as individuals, are regular donors to their programs. As well, they bring to the agencies support from the corporations, community groups and service clubs with which they are associated.

Loss of volunteer support will result in loss of funds coming into the system. The impact of the loss of goodwill provided by the volunteers will be translated directly into a loss of dollars to the long-term care system. It will also result in a significant loss in direct contact with the community and a loss of new volunteers. Volunteers are an excellent source of new volunteers for the agencies.

Whatever changes are made to the system, volunteers must be retained both for the services they provide and for the resources they contribute to the system.

Our third concern relates to specific aspects of multi-service agencies.

It is recommended that (1) the limit on services purchased in subsection 13(2) be eliminated in order to allow continued structural flexibility in the individual community planning process; (2) an exception be made to subsection 12(2) to provide for the option of individual consumer control over attendant care programs, thus maximizing independence and choice.

It is essential that there be sufficient flexibility to allow each community to develop an MSA system that builds on its strengths. It is not necessary, and may not even be desirable, for all services and care providers to be assembled under one roof and for consumers to have only one point of contact in the community. A functional integration of information, referral, assessment, case management, service delivery and follow-up in multiple locations may be what is required to develop a cohesive, integrated service.

Improved coordination and access to available services are highly desirable. Close coordination will be needed if there is more than one point of contact in a community. Communication among the providers is the key.

Continuity of service delivery must be maintained for clients, for the workers and for the volunteers. Agencies must maintain a viable volume of service delivery during the transition.

There is the concern that the limit of purchase of service by service category to 20% will force the amalgamation of agencies. Again it needs to be stressed that the legislation must allow local planning and maintenance of agency identity in some way that will ensure continued volunteer support.

The act must ensure that services are planned, delivered and evaluated from an integrated social service

and health perspective. We believe in a long-term care system that stresses the importance of maintaining and promoting health, wellness and early intervention in addressing client needs, and one that produces flexible service along a continuum of care.

Concerning attendant care, choice is critical for attendant care programs. Visiting Homemakers Association of Ottawa-Carleton administers the attendant care program for the Ottawa-Carleton region. They are aware at first hand of the need for an individual receiving services to choose who will provide the care and whether the individual wishes to direct his or her own care by direct funding.

Currently, they are conducting surveys to determine the wishes of the people receiving services through the attendant care program as to whether they wish their services to be outside an MSA or within it. It is strongly recommended that their choices be respected. This will require that flexibility be built into the access to the system.

In conclusion, we feel that these three issues, as well as those presented to you by other members of the Ontario Community Support Association, are representative of our concerns with Bill 173.

Our recommendations are that:

(1) Community support services, homemaking, personal support services and professional services be combined into a continuum of care. This approach will foster true integration of social and health services.

(2) Provision be made in the legislation to recognize the importance of the role of respite care services.

(3) Volunteer management in regulation 11 be expanded to require the development and implementation of a plan for the recruitment, training, scheduling, supervision, retention, recognition, and expense reimbursement of the volunteers.

(4) The limit on services purchased in subsection 13(2) be eliminated in order to allow continued structural flexibility in the individual community planning process.

(5) An exception be made to subsection 12(2) to provide for the option of individual consumer control over attendant care programs, thus maximizing independence and choice.

We appreciate the commitment of the provincial government to building partnerships with the community to plan and implement meaningful change, and the opportunity to express our concerns to the standing committee tonight. Thank you.

**Mrs Sullivan:** Thank you very much for a comprehensive brief. I think we'll all take note in particular of your recommendation with respect to attendant care programs, which have not been emphasized through the hearings to this point.

Your organizations would have participated in the consultative process with respect to long-term care reform. I'm interested in knowing if, in your view, people who appeared before the consultative committees and who participated in those hearings ever contemplated the kind of legislation that would be before us today.

**Ms Snyder:** It's very difficult to know what they were contemplating as they were listening to us. I know, as staff of the agencies and speaking to board members, they have been interested to watch the development and gradually understand the implications of the legislation. It certainly wasn't evident right at the outset.

**Mrs Sullivan:** Certainly, during those hearings and during that consultative process, the emphasis, it seems to me, was on a coordinated access, increased streamlining of the access to services to ensure that people didn't have to go through six or seven assessments but were dealt with in one way. But there was no demand or no clear cries, as far as I could tell, for a multiservice agency that was a monopoly and that put services like your own out of business. Did you see any of that? Did you see a call for the kind of approach that's being put forward in this bill?

**Ms Ann Hargest:** The philosophy that was put forward in the government documents indicated the importance of consumer-driven program with client choice, with service delivery being close to the people you are actually serving. This, to me, is extremely important. Certainly our agency, and I know others, felt that if these kinds of principles could be imbued in a system, we would be prepared to support it 100%. However, if we don't see that happening, perhaps the loss of identity of an agency becomes very important, because the number one thing—client service—is not going to be there.

**The Chair:** Thank you very much for coming before the committee tonight.

1920

#### HEALTH CARE UNIONS OF OTTAWA-CARLETON

**The Chair:** I call the next group. On your sheet it says the Ottawa-Carleton CUPE district council, but it's actually the Health Care Unions of Ottawa-Carleton, which represents a number of different organized labour groups. Welcome to the committee.

**Ms Betty Sommers:** My name is Betty Sommers and I'm the chairperson of the Health Care Unions of Ottawa-Carleton. Charlene Avon is from CUPE.

The Health Care Unions of Ottawa-Carleton represent members from the Canadian Union of Public Employees, the Ontario Public Service Employees Union, the service employees' union, allied and professional health employees' group, the Independent Canadian Transit Union and the Ontario Nurses' Association.

Through the Health Care Unions of Ottawa-Carleton, health care workers can fight for a say in how health care can be restructured locally. This group also provides support for our labour representative to the district health council and it ensures some accountability of those labour representatives to the labour community. We must organize a fight against steps to undermine the proper role of district health councils. The voice of labour will be heard.

Through the Health Care Unions of Ottawa-Carleton, health care workers can monitor the level of health services being provided in our community and we can alert the public to decisions by health care administrators

which will reduce the quality of care in our community. We are the glue which is holding an ailing system together. The Health Care Unions of Ottawa-Carleton recognizes the need to restructure the delivery of long-term care in the province of Ontario. Our concerns have been formulated into the following recommendations which we make to this committee.

**Governance:** Who should be represented on boards of multiservice agencies and district health councils, how they get selected and disclosure requirements: We believe that the bill's provisions in this area are extremely inadequate.

#### Recommendations:

(1) Section 11 of the bill should be amended to provide for a mix of appointed and elected representatives, based on the Quebec model for CLSCs and other health and social service facilities. This section should also be expanded to detail the procedures boards must follow to ensure openness and to spell out that financial and other operational documents should be readily available to the public.

(2) Section 17 of the bill prohibiting employees from being directors of agencies should be deleted.

(3) The standing committee on social development should urge the government to accept labour's position that labour should be able to nominate the labour names to district health councils through a joint Ontario Federation of Labour-Ontario Nurses' Association nominating committee. Bill 173 should be amended to provide that four labour appointees—two labour consumers, two labour providers—be represented on each district health council.

(4) Bill 173 should be amended to ensure that board members of multiservice agencies and district health councils be remunerated for any lost wages and expenses they incur in order to attend meetings.

**Direct provision of services:** Bill 173 weakens the government's earlier commitment to having multiservice agencies directly provide services.

#### Recommendations:

(1) Bill 173 should limit the purchase of services to a maximum of—we're not sure, zero, 5%, 10% of multiservice agency budgets for community support services, homemaking services, personal support services and professional services.

(2) Bill 173 should enshrine the preference for non-profit agencies and stipulate that where services are available from non-profit agencies, the MSA should provide such agencies with the opportunity to provide such service prior to purchasing them from a for-profit agency.

(3) Clauses 13(3)(b) and (c) should be deleted. These are the provisions which create exceptions to the rules governing maximum limits for the purchase of service where the purchase is in connection with short-term absences of employees due to illness, vacation or any other unplanned event, or where the service provider is a self-employed individual.

**Consumer rights:** While the bill provides for an appeal process for a review of agency decisions to deny persons

a particular service, there is no guarantee under the bill of a person's right to necessary care.

**Recommendations:**

(1) Bill 173 should enshrine the right of persons to any professional personal support, homemaking, and community support services which are necessary to enable them to live independently in their own home and in other community settings in dignity and with security.

(2) Bill 173 should clarify which agencies are responsible for providing professional personal support, homemaking, and other community support to persons who have been discharged from a hospital and who are in need of such services.

**Designation of multiservice agencies:** The bill's provisions contain a very strong bias against municipalities and public health units being designed as multiservice agencies. We do not agree with this approach.

**Recommendations:**

(1) Delete subsection 11(3), which makes municipalities and boards of health multiservice agencies "of last resort," from Bill 173.

**Employee liability and protection:** Provisions of the bill hold agency employees liable if they knowingly concur with the commitment of an offence under the act without providing them with whistleblowing and other protections.

**Recommendations:**

Bill 173 should be amended to provide employees with protection against refusing a direct order of their superiors to violate the act, as well as whistleblowing protection in circumstances where employees go public with information about offences under the act.

**Quality management improvement:** A number of provisions in the bill deal with employer quality management improvement programs, yet these programs are exempt from inspections.

**Recommendations:**

(1) Subsection 52(1) of the bill, which exempts records dealing with quality management activities or quality improvement activities from the inspection provisions of the act, should be amended to delete these exemptions.

**Volunteers:** Bill 173 contemplates regulations requiring MSAs to develop and implement a plan for recruiting and using the services of volunteers. We do not believe that the shift to community care should involve exploiting the unpaid labour of family care givers and friends, nor do we endorse volunteers performing the services currently provided by our members.

**Recommendations:**

(1) Section 20 of the bill, which provides for the development of a plan of service, should clarify that eligibility for in-home community services provided by approved agencies should be based on individual entitlement and should not be withheld or restricted on the basis that there is an unpaid care giver at home who is assumed to be able to perform those services on the person's behalf.

(2) Subsection 56(11) of the bill should be amended to clarify that any plan for the use of volunteers should be

restricted to activities not usually performed by members of bargaining units of unions which represent health and social service workers.

**1930**

**User fees:** The bill does not indicate which homemaking or community support services will be subject to user fees. There should be full public debate around which services multiservice and other agencies providing community services should be provided free of charge and which should be subject to user fees.

**Recommendations:**

(1) The standing committee on social development should urge the government to make a commitment that before any regulations are made which permit the charging of user fees for homemaking or community support services, a discussion paper on the subject will be released and further public consultations should be conducted.

(2) Subsection 26(2) of the bill, which allows a contracted service provider to collect user fees from a recipient of a service, should be deleted.

**Fair wages and employment security:** The government has failed to adequately meet the needs and concerns of workers who will be displaced as a result of health care restructuring in general and the consolidation of services under the authority of MSAs in particular. There are no provisions in Bill 173 to ensure that MSA employees will be entitled to similar wages and working conditions, nor are there provisions to ensure that wages and benefits of community-based health care workers are comparable to the wages and benefits of other health care workers.

**Recommendations:**

(1) The standing committee on social development should urge the government to ensure that multiservice and other community-based agencies should be adequately funded to provide high-quality services and pay and benefits which are comparable to the level which exists in the municipal and institutional care sectors.

(2) The standing committee on social development should urge the government to initiate a process for a province-wide employment security agreement which provides the framework for an effective and enforceable redeployment system to be administered by HSTAP to ensure that workers who are displaced by health care restructuring are placed in comparable pay and benefits in other parts of the health care system.

**Mr Sterling:** I'm flabbergasted at your remarks about volunteers. Number one, do you not understand that family members and community members want to help their brethren in a time of sickness or in a time of need and they don't want to be paid? Do you think we should deny them that right to help their family and friends?

**Ms Sommers:** I'm not saying that they should be denied, but they shouldn't be forced to be in that kind of a situation either.

**Mr Sterling:** Do you think they're forced?

**Ms Sommers:** I see it in this bill—

**Mr Sterling:** How are volunteers forced? How are volunteers forced to volunteer?

**Ms Sommers:** If there's nobody else there to do it.

**Ms Charlene Avon:** There are ways that they are forced into it. This is a society which is very proactive with two people working in it to keep the standard of living that's going. If you put barriers up where one person has to stay at home and take care of it, whether they want to or not—I may well want to stay home and take care of someone.

I may well not be able to afford it. I may well have to get out and support the family. Then you're putting barriers up to those people. Then there should be other options. There are options and opportunities for people to stay home, and well be it; great. We're not saying that they shouldn't. We're saying—

**Mr Sterling:** But if we take the premise that we're operating at a deficit in this province of approximately \$8 billion to \$10 billion a year and there isn't any more money, would you rather have a volunteer providing the service or would you rather have nobody providing the service?

**Ms Avon:** I want to know where you're going to get the volunteers, first of all, because as a health care worker and now as a person—

**Mr Sterling:** No, no, no. Answer my question.

**Ms Avon:** I'm going to answer your question.

**Mr Sterling:** Where are we going to get the money?

**The Chair:** Order, please.

**Mr Sterling:** No, no. I mean, I'm asking a question.

**The Chair:** I know, that's fine, but just let her answer—

*Interjections.*

**The Chair:** Order, please. Order. Mr Sterling, order, please.

*Interjections.*

**The Chair:** Mr Martin, please. Order, please. The witness is trying to answer the question, and I would ask that everyone give her the time to do that.

**Mr Sterling:** It's ridiculous. It's a disgrace to our volunteers.

**The Chair:** Please go ahead.

**Ms Avon:** We have no disgrace to the volunteers. What we are trying to say is that—and what I am trying to say is as a health care worker who worked in the system for 10 years before I became a staff member for CUPE, I can relate to health care and to the giving of the health care services.

What I'm saying is, there are volunteers out there, as we all well knew, with the biggest hearts and the best of intentions who have no idea of how you address or treat someone with diabetes, someone who should be eating properly. We have and I have known of cases where people have gone in and with every good intention have cut Grandma Somebody or Other's or Grandpa Somebody or Other's toenails, caused that toenail to bleed, break into the skin and set in gangrene—done with good intentions, but still with not the knowledge that this can happen.

They have been giving diabetics food that they

shouldn't have. They have given people with special diets food they shouldn't have—good intentions. We're not saying it's wrong, that we delete all volunteers, but be realistic about it. Look at who is giving that care.

**Mr O'Connor:** I would suggest that you maybe take a look at a presentation made to us from York community care. It was rather astounding that—because I do believe that your membership is actually represented by that group—seem to be somewhat not reflective of some of the good work that's probably being provided by those staff members.

In your last recommendation you talked about HSTAP. One of the things that we have heard by presenters is what about—

**The Chair:** Mr O'Connor: HSTAP, can you just identify what that is, because I'm sure for a lot of people that—

**Mr O'Connor:** It's the training and adjustment program, but for health services.

**The Chair:** Thank you, just so we all understand.

**Mr O'Connor:** All right. What's been suggested to us is that only the unionized personnel will be able to access this type of service. What would you suggest then as the progress evolves would be put in place for some employees who may not have the benefit of a bargaining agent there to represent—their potential for displacement. I know that we are going to require a human resources plan, but if you would react to that which has been brought to the attention of the committee.

**Ms Avon:** HSTAP I think is something that's very credible that the government has put forward. Basically, it is right now for the unionized workforces. What we know—and because I represent an awful lot of nursing homes in this area under CUPE—is that management has the same evolution. They are bringing in human resource people to help them with their troubles that they're going through too.

There's no reason why it can't be done for non-union people or middle management. It's a partnership. What we're saying is there has to be now a playing field where we're all involved, because management are being affected, non-union are being affected, union are being affected. They all affect the people who we're here for, the patient, the care receiver, who is the basic—otherwise none of us would be working and we wouldn't have to worry about it.

I think we have to work in partnership and look at what the model is, along the same lines as we did with pay equity, if you remember. Pay equity came in for unionized workplaces, then looked at non-union workplaces and then looked at various ways—those are the models that are out there. I say, use them.

1940

**Mr O'Connor:** It's possible it would be useful if we could request maybe somebody from HSTAP to either present something to us in a written form that we can take a look at, as suggested here, or perhaps somebody come and make a presentation to us.

**The Chair:** Thank you both for coming before the committee this evening; we appreciate it.

## ADDICTION RESEARCH FOUNDATION

**The Chair:** I then call on the representative from the Addiction Research Foundation. Welcome to the committee.

**Ms Christine Bois:** Good evening. We're pleased to be able to have the opportunity to present this brief. Let me assure you, I will be brief. This will be about 10 minutes. You've allocated me 20.

The Addiction Research Foundation is concerned about the use of psychoactive drugs by older people in Ontario. The Addiction Research Foundation is an agency of the province of Ontario. We have a mandate to conduct research into drug use and abuse, to share knowledge, develop programs and services to benefit the people of Ontario. Over the past 20 years, the Addiction Research Foundation has been active in addressing issues related to substance use among seniors.

In our comments today, we would like to show our support for the principles that Bill 173 will introduce. But we would also like to draw your attention to the importance of addressing substance use and abuse among seniors in the provision of long-term care services.

Our concern is illustrated by a quote from a book called *Old and Smart* by Betty Nickerson:

"You may start out taking a pill for high blood pressure and, as a result, develop a wheeze. Instead of switching blood pressure pills, you are now prescribed a new medication for asthma, which upsets your stomach and prevents you from sleeping. To treat the stomach, you are prescribed a Tagamet, which causes mental confusion. Because of jitteriness and insomnia, valium is added, yet Tagamet increases the level of valium in the blood and makes it more toxic. What started out as a blood pressure problem winds up being diagnosed as possible senile dementia."

And of course, as we know, people with senile dementia need care, perhaps in an institution.

Let us consider some of the facts about seniors and drug use. Seniors receive proportionately more prescriptions than any other age group. They are also the least able to metabolize alcohol and other drugs because of the changes that occur as people age. This places seniors at high risk: the adverse effects of medications and of the interactions between alcohol and medications. There is a high risk also for alcohol and other drug problems being mistaken for the signs of aging.

The side-effects of sleeping pills, tranquilizers and pain medication include feeling confused, poor memory, dizziness, unsteadiness or falling, headaches, nausea, constipation, irritability and feeling jittery. That, of course, sounds like the signs of aging. When these symptoms occur over a long period of time, the side-effects can lead to isolation, conflicts with family and friends, poor eating and self neglect.

Seniors 60 and over are more likely to use tranquilizers and sleeping pills than other ages. Their use is two to three times greater than younger people.

The rates of adverse effects of drugs are significant. Also significant are the consequent use, in emergency departments and the health care system in general, by

seniors who have drug-related problems.

Seniors 65 and up in Ontario are the most likely age group to drink daily—at a rate of 17.9%.

Obviously, alcohol can be used in combination with other drugs, and this produces very serious consequences.

I have mentioned that seniors who take mood-modifying medications do not metabolize drugs and alcohol as efficiently as younger people. In addition, older adults often use multiple medications for their physical problems. Even non-psychoactive medications can interact with alcohol and other psychoactive drugs.

Concern about the adverse effects of drugs has been recorded actually in the past. Three hundred years ago, the French writer Molière wrote, "Nearly all men die of their medicines, not their diseases." I would like to paraphrase that quote to read, "Nearly all men and women die of their medicines, not their diseases."

The long-term care system is changing and now, 300 years after Molière penned his criticism of drug use, it is time also to look at how we change drug use.

Both nationally and within Ontario, a number of organizations have focused on the use of medication by older adults. For example, the inappropriate use of medication by seniors was addressed in the report of the Pharmaceutical Inquiry of Ontario known as the Lowy commission. This important issue was also considered in the work of the Canadian Coalition on Medication Use and the Elderly and the Ontario drug benefits reform secretariat.

Last fall, the Ministry of Health released a substance abuse strategy called *Partners in Action*, and within that strategy seniors were identified as a priority population. The provincial strategy noted that a number of initiatives should lead to better pharmacotherapy among the elderly. These initiatives include building on the work of the drug reform secretariat and the potential implementation of a drug utilization review capability. Other initiatives include developing appropriate experience and training for medical and pharmacy students, and establishing linkages with the long-term care reform process.

The provincial drug strategy also named people with disabilities as a priority population. People with disabilities often do have acute care needs. Studies have shown that they are also at risk of developing problems related to drug and alcohol use. Presently the Addiction Research Foundation has a committee working to address the needs of people with disabilities.

The work of the Addiction Research Foundation is consistent with the ministry substance abuse strategy. We are planning activities, directing research and developing resources to address these priority populations: Ontario's seniors and people with disabilities.

With respect to Bill 173, the Addiction Research Foundation agrees with and supports the following principles:

(1) That consumers and their families and care givers will benefit from a long-term care system that is more accessible, better integrated and coordinated.

(2) That the act will strengthen the mandate of district health councils by giving them a legislative framework.

The Addiction Research Foundation works in collaboration with district health councils at the community level. We support their work with the community and we support the coordination of planning by district health councils.

(3) That the governance of the service at the local level includes a significant number of consumers and family members. This will help to ensure that the services are responsive to people's needs.

(4) That support services will be delivered to people in their homes and in other community settings as an alternative to institutional care.

Providing service to people in their homes is consistent with our best advice on addressing problem drug use by older adults. It is consistent also with the approach of two long-standing agencies that provide services to seniors in Ontario with substance abuse problems. The Addiction Research Foundation did play a major role in the development of these effective programs. They are the community older persons alcohol program, otherwise known as COPA, based in Toronto; and lifestyle enrichment for senior adults, or LESA, here in Ottawa.

These programs have actually provided models for program development in other parts of Canada and elsewhere in the world. The Addiction Research Foundation staff, specifically a Dr Kate Graham, was involved in the evaluation of these two programs and this has fostered the international dissemination of innovative evaluation approaches.

These two programs serve as models for addressing substance abuse problems for older adults using an approach that is holistic, coordinated and community-based. They are a client-centred program that understands the context of an older person's substance use and the consequences of that use.

(5) The development of multiservice agencies will ensure the integration and coordination and access to services. In the interests of ensuring that substance use is considered in the provision of long-term care, the Addiction Research Foundation has consulted with staff of the ministry's long-term care division about the development of the assessment instrument. This instrument, which will be used by resources managers in multiservice agencies, could fully assess substance use and its impact on the health and lifestyles of Ontarians.

We would be happy to continue to provide consultation about screening questions that will identify the use and abuse of mood-modifying drugs, including alcohol, prescription and over-the-counter drugs. We would like to help ensure that the assessment tool which is developed is sensitive to drug problems.

**1950**

The Addiction Research Foundation's position is that training is important. If the assessors who identify and intervene with people are sensitive to problems related to the use of alcohol and other drugs, it will go a long way towards preventing the need for institutionalization or other more complex care with its increased burden for the informal care givers.

Techniques have been developed for successfully

intervening with older people once an alcohol or drug problem is identified. These techniques need to become known by the front-line workers in the long-term care process. ARF would be happy to work with the staff of the ministry's long-term care division and with the district health councils to ensure that this training is available locally as the multiservice agencies are implemented.

A training package has been developed and is available. The Addiction Research Foundation collaborated with LESA and COPA to develop a training program for care givers who work with older people. The program is called Alternatives in English, and Options in French. It consists of a training manual, a presentation for older adults, a separate presentation for care givers and a video.

In addition, within Addiction Research Foundation's planning, the training of medical and pharmacy students is being addressed. Initiatives must be developed that include components relevant to substance use by older men and women. These initiatives should improve pharmacotherapy for this age group and ensure that seniors' alcohol use is also appropriately addressed.

Education of the consumer is also important. A number of pamphlets and education materials are available, including two pamphlets being distributed by the Addiction Research Foundation across Ontario. One is called The Older Adult and Alcohol, the other The Older Adult and Sleeping Pills, Tranquilizers, Pain Medication.

In conclusion, alcohol and other drug use increases the risk of premature institutionalization for older people. Drug use can also reduce a person's quality of life and add significant financial burden to the health and social service system. It is therefore important that these issues are addressed as Ontario's long-term care system is redirected. An opportunity exists to tackle these issues with training for in-home workers and support staff, a sound curriculum for students and the development of assessments that are sensitive to drug use problems among seniors and people with disabilities.

The Addiction Research Foundation is pleased at the opportunity long-term care reform has presented in terms of working with both old and new partners to develop suitable education and training for care givers and students. As the province and the community begin to develop the intake and assessment form for multiservice agencies, we welcome the opportunity to work in concert with them.

**Ms Carter:** I very much appreciated your presentation, because this question of excessive drugs, particularly in relation to seniors, is one that I'm very concerned with myself. What you said about medicines isn't actually just funny. I believe about 20% of hospital admissions of seniors is due to drug-related problems.

**Ms Bois:** Actually, 33% of all adverse drug reactions occur in seniors and they are only 12% of the population.

**Ms Carter:** And of course there are some related deaths as well.

**Ms Bois:** Yes.

**Ms Carter:** So this is a very serious matter. I'm sure the ministry is very aware of this problem. It's certainly

something we have in mind and obviously want to do everything we can about. You didn't mention that we do have in place now a computerized system where pharmacists can check when somebody comes in with a prescription, which will immediately tell them if there's a conflict or they're getting a double dose of the same medication or something of that nature. Could you comment on that?

**Ms Bois:** I did mention the drug review utilization capability. Unfortunately, I'm not fully cognizant of exactly what that computer network is doing at this point, but certainly it is a useful step in the direction of ensuring. I think pharmacists have a significant role to play in monitoring and providing education to the drug user.

**Ms Carter:** I think we've all been encouraging that function of pharmacists. I wonder if we could hear something about how that system is working.

**Mr Jim Wilson:** We just had a briefing on it last week. It's still got a few flaws.

**Ms Carter:** I wasn't here last week so I missed that.

**Mr O'Connor:** May I make a suggestion, Mr Chair? The public accounts committee had a presentation by ministry officials on that program. If you'd like, the clerk could probably get a copy of the last day of public accounts hearings where we had Ministry of Health officials there. They actually had a very good overview presentation and showed how many prescriptions that had adverse reactions to them were caught as a result of the system and the health impacts that would have been saved as a result of that, which is really quite incredible.

**The Chair:** We can do that. We'll get that circulated.

**Ms Carter:** Okay, so that is in place. Also, of course, the Drug Quality and Therapeutics Committee is very much maligned because people say we're cutting back on the drug plan, but actually I think what happens on an ongoing basis—and I believe it always has—is that some drugs are weeded out as not being considered effective or as being even harmful.

**Ms Bois:** Our position is to encourage people to consider alternatives at times for drug use that are available.

**Mrs Sullivan:** I think this was an important and interesting presentation to the committee and quite different than any that we've had in the past. We have certainly all, I think, been made more aware of the issues about drug abuse among seniors and misuse since the Lowy report, because it brought the issues right down to earth in a highly communicative way, and I think that was useful to us all.

My own sense is that pharmacists themselves have started to adopt a pharmaceutical care model that's more responsible than they ever have in the past, and that change is going to be at the younger level, at the newer graduates in pharmacy who are coming forward and who will, it seems to me, be trained to work in a multi-disciplinary environment along with physicians. That change is not going to occur overnight.

I am, however, interested in your suggestions that the assessors who are making determinations about eligibility and needs for care of people who are entering the long-term care system should be able to identify some of the

drug abuse or misuse problems which occur with applicants, particularly given the fact that there is a significant amount of concern with respect to the implementation of this bill as to how clinical expertise will be brought into the pattern. In other words, the assessor may well get a list of the over-the-counters and the prescription medications that the patient's receiving but won't be able to do anything about it, and there's doesn't seem to be a viable way that the pharmacist or the physician is then brought into the system to help devise a program to get the patient off the drugs or to work out a method of making a well person there.

I just wonder how the ARF and you see the step between the assessor and moving into a healthy environment for the patient.

**Ms Bois:** What you've said, the importance of ensuring that the physician and the pharmacist are working in collaboration with the assessor, is key, and I think that when we talked about training we've talked about training at kind of the institutional level—that is, at the university—to emphasize at that point the importance of assessing and the sharing and coordination of information. We're talking about trying to deal with it at the training level. But I think at the training level, when we're talking about the MSAs being implemented, it would be wonderful to have the physicians become involved in that training as well. We're not sure how feasible that is, but I think there's a gradual understanding that they are part of the system and will have to be working in concert with people who are working in the homes.

**2000**

**Mrs Sullivan:** Could I just have a little addendum? When you have made your recommendations on the assessment questions, have you included over-the-counters as well as prescription medication?

**Ms Bois:** I would hope so. I wasn't involved in the initial consultation on that, but certainly we would encourage that, definitely, along with alcohol and over-the-counter. They're the two drugs that often are missed when we deal with the elderly. We often only think of prescription drugs.

**The Chair:** Thank you very much for coming before the committee this evening.

CENTRE DE SANTÉ COMMUNAUTAIRE DE L'ESTRIE

**Le Président :** J'aimerais maintenant inviter, pour faire notre dernière présentation, le représentant du Centre de santé communautaire de l'Estrie, M. Beaulieu. Vous êtes bienvenue. Merci aussi pour le paquet que vous nous avez présenté. Nous avons aussi là-dedans une copie de votre présentation. Alors, nous sommes entre vos mains.

**M. Roland Beaulieu :** Mesdames et messieurs les membres du Comité permanent des affaires sociales, bonsoir. Mon nom est Roland Beaulieu. Je suis directeur général du Centre de santé communautaire de l'Estrie, Cornwall-Alexandria. Nous couvrons les trois comtés unis de Stormont, Dundas and Glengarry.

Je me dois tout d'abord de vous remercier sincèrement d'avoir bien voulu accepter de me rencontrer à une heure tardive avec un agenda aussi chargé. C'est que j'ai réalisé

à la dernière minute qu'il n'y avait peu ou pas de représentation de l'est ontarien. Quand je parle de l'est ontarien, je dis bien un peu plus loin qu'Ottawa, en allant vers le Québec.

**Le Président :** Le vrai est.

**M. Beaulieu :** Le vrai est. Je n'ai pas à m'attarder non plus sur le mandat des centres de santé, leur évolution et leur place dans la communauté. Vous avez déjà rencontré les représentants des centres de santé de la région d'Ottawa qui vous ont décrit comment les centres de santé se voient comme participants dans le développement des OSP.

J'aimerais vous parler de notre région de Stormont, Dundas et Glengarry, le parent pauvre de la province. Certains parlent même du Bangladesh de l'Ontario ; ça veut dire que ce n'est pas loin de la pauvreté. Souvent oublié et méconnu du reste de la province, ce coin de province, mélange harmonisé d'anglophones et de francophones, a des besoins spécifiques en termes de soins de santé. La mise sur pied d'un centre de santé francophone pour desservir les trois comtés unis manifeste déjà les besoins spécifiques de notre communauté. Il remettait aux francophones une gamme de services dans leur langue répondant à leurs besoins.

La venue d'un accès unique au sein des soins de longue durée est attendue depuis plusieurs années. La mise en oeuvre des OSP va permettre la réalisation d'un tel projet. Il est donc très important de s'assurer que les OSP répondent aux besoins de la communauté en général et également de la communauté francophone ontarienne.

Les bénéficiaires des services de soins de longue durée sont principalement des personnes âgées. Étant donné que dans les comtés de S-D-G la population de personnes âgées est plus élevée que la moyenne provinciale et que 35 % de cette population est francophone, il est important que la population âgée reçoive des services dans leur langue maternelle. Vous savez très bien que les personnes âgées de 50 ans et plus sont les personnes qui très souvent ne sont pas bilingues ; elles sont unilingues francophones ou bien unilingues anglophones. La majorité de ces personnes ne peuvent communiquer en anglais dans leur quotidien et encore moins lorsqu'il s'agit d'organiser des services de soins de longue durée pour eux ou pour un membre de leur famille.

Madame la ministre, dans son allocution le 6 juin 1994 présentée devant l'Assemblée législative, nous dit, et je cite : « Je m'engage à ce que les organisations de services polyvalents situées dans les régions désignées en vertu de la Loi sur les services en français offrent des services dans cette langue, et je ferai en sorte que les organisations de services polyvalents concernées soient désignées en vertu de cette Loi. » De plus, dans le document intitulé Partenariats dans les soins de longue durée : Un nouveau moyen de planifier, d'administrer et d'offrir des services et du soutien communautaire — Directives d'établissement des organismes de services polyvalents, on peut y lire en page 2, « Dans les régions de la province visées par la Loi sur les services en français, on offrira des soins de longue durée en français aux Ontariens et aux Ontariennes francophones. » On retrouve également, dans les principes directeurs des OSP, l'énoncé suivant, « encour-

ager l'équité raciale et la sensibilité culturelle ». Il est donc évident que les recommandations de la Ministre sont d'offrir des services en français à la population francophone, mais dans les différents documents on ne fait pas référence à la mise en oeuvre d'un tel service. Nous pensons donc qu'en tant que centre de santé communautaire francophone, il est de notre responsabilité de vous conseiller sur la façon d'assurer des services en français aux Franco-Ontariens.

Dans le passé, dans la région des comtés de Stormont, Dundas et Glengarry, certains services se disaient francophones, mais dans la réalité la seule personne qui parlait français était la réceptionniste. Ce n'est pas ce que nous appelons des services en français. De plus, lorsque le service se dit bilingue, même si les gens font un effort véritable pour offrir des services aux francophones dans leur langue maternelle, dans la réalité, plus d'effort est mis sur les services offerts en anglais.

Pour rejoindre les francophones, il faut les connaître : connaître leurs habitudes, leurs traditions, leur culture, et qui mieux qu'un francophone pour faire ce travail ? Pour les rejoindre, il faut être un organisme francophone. L'exemple des différents organismes francophones de la région est la preuve vivante qu'il est possible de rejoindre ceux-ci, alors que certains organismes bilingues nous répètent continuellement que les francophones ne peuvent être rejoints.

Le Centre de santé communautaire dessert déjà, après deux ans et demi, plus de 900 personnes de 50 ans et plus, ce qui correspond à 32 % de notre clientèle. De ces clients, nous desservons une trentaine de personnes à domicile, personnes qui normalement devraient être en institution ou à l'hôpital. Nos médecins, infirmières, travailleurs sociaux ou psychologues se rendent à domicile pour donner du traitement ou du support aux clients et à leur famille. Cette gamme de services pourrait s'améliorer avec la venue d'un OSP francophone, et encore mieux si ce OSP se rattachait au Centre de santé. C'est pourquoi nous recommandons fortement qu'il y ait deux OSP pour couvrir Stormont, Dundas et Glengarry, soit un francophone et un anglophone.

De plus, à la lecture des différents documents sur les OSP et du document intitulé Centres de santé communautaires de l'est de l'Ontario : Une vision pour les organismes de services polyvalents en matière de soins de longue durée, produit par les CSC de l'est de l'Ontario, il apparaît évident que les centres de santé communautaires ont une structure et une philosophie similaire à celle émise pour les OSP. Si vous regardez les tableaux, vous voyez que dans les principes des OSP et les principes des CSC, on se rejoint facilement.

Dans les principes qui ont trait aux OSP et que l'on retrouve à la page 6 du document Directives d'établissement des organismes de services polyvalents, nous retrouvons : respecter et appuyer le désir de dignité, de bien-être et d'autonomie des gens. Principe des centres de santé : engagement à donner aux personnes et aux collectivités les moyens de se prendre en charge.

Principe des OSP : intégrer les services de santé et les services sociaux de longue durée. Principe des centres de santé : engagement à fournir des soins globaux, travail

d'équipes multidisciplinaires et travail dans la communauté avec la communauté.

Principe des OSP : assurer une plus grande participation des clients et un plus grand contrôle dans la planification et la prestation des services. Principe des centres de santé : encourager la participation des clients dans la planification des services soit par le biais du conseil d'administration ou du développement communautaire.

#### 2010

Je vais faire une parenthèse ici. Les centres de santé sont administrés par un conseil d'administration dont 50 % des participants au conseil d'administration sont des clients du centre. Également, les centres de santé ont un comité, qui s'appelle comité des clients, pour faire étude des besoins réels des clients face aux programmes qui sont donnés.

Je reviens aux principes des OSP : encourager l'équité raciale et la sensibilité culturelle. Les centres de santé, dans leur engagement à offrir des services accessibles, précisent, «Les centres de santé communautaires déploient des efforts particuliers afin de satisfaire aux besoins des personnes...dont l'accès aux soins de santé requis est difficile en raison de barrières linguistiques ou culturelles.»

Principe des OSP : l'approche recommandée pour les OSP me semble une approche communautaire, et qui mieux que les CSC déjà logés dans la communauté pour rejoindre les gens de la communauté ?

En dernier lieu, un sujet qui nous inquiète beaucoup face à cette nouvelle Loi sur les soins de longue durée, c'est comment cette Loi protégera les services en français aux aînés. C'est pourquoi le Centre de santé désire demander à la commission et à la ministre de la Santé de garantir l'inclusion des services en français dans la Loi sur les soins de longue durée, protégeant ainsi les droits des francophones. De plus, le Centre de santé communautaire de l'Estrie propose que la Ministre désigne des OSP francophones pour desservir les régions désignées sous la Loi des services en français, et ceci dès la création des OSP dans les régions désignées.

Mesdames et messieurs, un grand merci pour votre attention et votre collaboration. Je demeure disponible pour répondre à vos questions.

*Interruption.*

**Le Président :** Merci beaucoup. Ce n'est pas une question, là.

**M. McGuinty :** Merci beaucoup pour votre présentation ce soir. Jusqu'à cette date-ci, est-ce que vous avez reçu les assurances que vous cherchiez de la Ministre que vous allez avoir des OSP francophones pour desservir les régions désignées sous la Loi des services en français ?

**M. Beaulieu :** Il n'y a pas eu de garantie comme telle dans la Loi. Madame la ministre nous a dit qu'elle ferait tout dans son pouvoir pour qu'il y ait des OSP désignés dans les régions désignées, mais il n'y a rien dans la Loi qui nous garantit ceci.

**M. McGuinty :** Peut-être que nous devrions donner la chance à l'adjoint parlementaire pour nous donner une garantie, disons, que nous allons avoir un OSP francophone du moins à Cornwall. Nous allons lui donner la chance de répondre à cette question-là maintenant.

**Une voix :** Maintenant, ce soir.

**Le Président :** Monsieur l'adjoint parlementaire. Un cadeau à la fin de la soirée.

**Le Président :** Joyeux Noël.

**Mr Wessinger :** I'm afraid I won't be able to—well, I might do it privately, but I'd be afraid to try it publicly, my French. But certainly as I understand it, there's been a clear commitment. I think that where areas are designated under Bill 8, an MSA will be designated in those areas to provide the services in French. I think Mr Quirt has indicated that earlier, but I don't believe there's anything beyond that assurance, which is certainly a definite assurance. I don't know if Mr Quirt could add anything.

**Mr Quirt :** I think recently ministers Grier and Pouliot wrote to district health councils across the province reminding them of their obligation to plan effectively for French-language services in those designated areas, and I believe she's made it clear to district health councils that it is her intention to designate MSAs under the French Language Services Act. You're right that there isn't a specific reference to the French Language Services Act in our bill, but the French Language Services Act governs government operations. That's why there is a separate act, so that the provisions of that act don't have to be repeated in every other piece of legislation the government has ever passed.

**M. Beaulieu :** Merci beaucoup. Thank you very much.

**Le Président :** Merci beaucoup, et on va voir dans l'avenir.

**M. Beaulieu :** C'est qu'on parlait de Cornwall tantôt, et j'apprécie beaucoup. J'aimerais bien en avoir un à Cornwall, mais notre mandat est de couvrir les trois comtés unis de Stormont, Dundas et Glengarry. Alors, on aimerait que la population de cette région puisse être desservie dans sa langue, surtout les personnes âgées.

**Le Président :** Encore une fois, merci pour le document que vous nous avez donné ce soir.

**M. Beaulieu :** Ça me fait plaisir.

**The Chair :** Members of the committee, that brings to a conclusion our hearings today in Ottawa. I know some members will be going back to Toronto tonight, others tomorrow. We begin again tomorrow morning in committee room 1 at Queen's Park at 10 o'clock sharp. We have a busy day, ending, of course, going to Kingston, where we will be in hearings on Wednesday.

With that, I want to thank everyone here at the Delta Hotel in Ottawa, the ministry staff and others.

*The committee adjourned at 10:17.*

Sisters of Charity of Ottawa Health Service .....	S-2084
Michel Bilodeau, president	
Ottawa West Seniors Recreation Advisory Committee .....	S-2086
Tom Sparling, manager, recreation and volunteer services, Beacon Hill Lodge.	
Karen Colby, recreationalist, Central Park Lodge	
Lindsay Webber, recreation therapist, geriatric psychiatry department, Royal Ottawa hospital	
Ontario Home Care Case Managers' Association, eastern region .....	S-2089
Judi Burke, membership secretary	
Susan McGurn, regional representative	
Canadian Red Cross Society, Ontario division, Ottawa-Carleton branch / Société canadienne de la Croix-Rouge, division de l'Ontario, section d'Ottawa-Carleton .....	S-2092
Jane Levoy, manager, homemaker service, Renfrew North	
Madeleine Germain-Kennedy, client, homemaker service	
Senior Citizens' Consumer Alliance for Long-Term Care Reform, Ottawa branch .....	S-2095
Bert Hanmer, representative	
Ontario Community Support Association, area 10 .....	S-2096
Janet Snyder, executive director, King's Daughters Dinner Wagon	
Ann Hargest, member, Visiting Homemakers Association of Ottawa-Carleton	
Health Care Unions of Ottawa-Carleton .....	S-2099
Betty Sommers, chair	
Charlene Avon, national staff representative, Canadian Union of Public Employees	
Addiction Research Foundation .....	S-2102
Christine Bois, program director	
Centre de santé communautaire de l'Estrie .....	S-2104
Roland Beaulieu, directeur général	

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \*Chair / Président:** Beer, Charles (York-Mackenzie L)  
**Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)  
**\*Carter, Jenny** (Peterborough ND)  
**Cunningham, Dianne** (London North/-Nord PC)  
**Hope, Randy R.** (Chatham-Kent ND)  
**\*Martin, Tony** (Sault Ste Marie ND)  
**\*McGuinty, Dalton** (Ottawa South/-Sud L)  
**\*O'Connor, Larry** (Durham-York ND)  
**\*O'Neill, Yvonne** (Ottawa-Rideau L)  
**Owens, Stephen** (Scarborough Centre ND)  
**Rizzo, Tony** (Oakwood ND)  
**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Gigantes, Evelyn, (Ottawa Centre ND) for Mr Rizzo  
Malkowski, Gary (York East/-Est ND) for Mr Hope  
Sterling, Norman W. (Carleton PC) for Mrs Cunningham  
Sullivan, Barbara (Halton Centre L) for Mr Eddy  
Wessinger, Paul (Simcoe Centre ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

Ministry of Health:  
Czucar, Gail, legal counsel  
Quirt, Geoff, acting executive director, long-term care division  
Wessinger, Paul, parliamentary assistant to the minister

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Boucher, Joanne, research officer, Legislative Research Service

# CONTENTS

Monday 12 September 1994

<b>Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,</b>	
projet de loi 173, M <sup>me</sup> Grier	S-2039
Lise Nolet	S-2039
Victorian Order of Nurses, Eastern Counties, Pembroke, Ottawa-Carleton and South Renfrew branches	S-2044
Beth McDonald, executive director, Ottawa-Carleton branch	
Charles Armstrong, president, Ottawa-Carleton branch	
Joan Booth, president, South Renfrew branch	
Ottawa-Carleton Community Health Centres	S-2046
Martha Smith, manager, seniors program, South-East Ottawa Community Services	
Karen Stotsky, executive director, Centretown Community Health Centre	
David Hole, executive director, South-East Ottawa Community Services	
Peggy Feltmate, executive director, Community Resource Centre of Goulbourn, Kanata and West Carleton	
Community Support Coalition of Ottawa-Carleton	S-2049
Ginette Rashleigh, manager, home support program, Gloucester Centre for Community Resources	
Carol Halstead, administrator, home support program, township of Osgoode	
St Patrick's Home of Ottawa	S-2051
Maureen Goodspeed, board chair	
Bradson Home Health Care	S-2054
Allayne Evans, vice-president	
Margaret Simons, home support worker	
Marianhill	S-2057
Isabel Leach, coordinator, Dr L.U. McCluskey Centre	
Eileen Sicoli, coordinator, pastoral care	
Service d'entraide communautaire pour les aînées et les aînés francophones	S-2060
Denise Chevrier, vice-présidente	
Pierre Périard, directeur général	
Union of Ontario Indians	S-2062
Dr Alan Roy, health director	
Vernon Roote, deputy grand chief, Anishinabek Nation	
Regional Municipality of Ottawa-Carleton	S-2065
Peter Clark, chair	
Garry Armstrong, commissioner, homes for the aged	
Betty Margeson	S-2068
Ottawa-Carleton Regional District Health Council	S-2071
Jacqueline Neatby, long-term care committee	
Avril Gunter, chair, multiservice agency working group	
Council on Aging for Ottawa-Carleton	S-2074
Sylvia Goldblatt, president	
Jean Shaw, chair, long-term care task force	
County of Renfrew	S-2077
Alvin Stone, warden	
Andrew Dickson, reeve and member, welfare and homes for the aged management committee	
Michael Johnson, chief administrative officer and treasurer	
Ontario Hospital Association / Association des hôpitaux de l'Ontario	S-2081
Laurent Isabelle, chair-elect/président élu ou désigné	
Dan Drown, senior consultant, chronic care, mental health and rehabilitation division	
Michel Bilodeau, president, Council of Chronic Hospitals of Ontario	

*continued overleaf*

CA201  
XC 12  
-577

Indications

S-67



S-67

ISSN 1180-3274

**Legislative Assembly  
of Ontario**

Third Session, 35th Parliament

**Assemblée législative  
de l'Ontario**

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

**Tuesday 13 September 1994**

**Journal  
des débats  
(Hansard)**

**Mardi 13 septembre 1994**

**Standing committee on  
social development**

**Long-Term Care Act, 1994**

**Comité permanent des  
affaires sociales**

**Loi de 1994 sur les soins  
de longue durée**

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary      1944 – 1994      50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 13 September 1994

Mardi 13 septembre 1994

*The committee met at 1006 in committee room 1.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Acting Chair (Mr Dalton McGuinty):** Good morning, ladies and gentlemen. I want to draw to committee members' attention that we have been provided with a second draft summary of recommendations for our perusal.

ASSOCIATION OF ONTARIO PHYSICIANS  
AND DENTISTS IN PUBLIC SERVICE

**The Acting Chair:** The first presentation this morning will be made on behalf of the Association of Ontario Physicians and Dentists in Public Service.

**Dr Martin Chisvin:** I'm Martin Chisvin. I'm a geriatric psychiatrist at the Queen Street Mental Health Centre here in Toronto. Michael Kugelmass is also a geriatric psychiatrist at Queen Street. Jansz Duksza is a rehabilitation psychiatrist at Queen Street and president of our association. Debra Eklove is the executive director of our association.

The Association of Ontario Physicians and Dentists in Public Service was formed in 1974. Membership includes 400 full- and part-time salaried psychiatrists, general practitioners and dentists. Most of our members work in Ontario's 10 provincial psychiatric hospitals and nine Ministry of Community and Social Services regional centres for the developmentally challenged.

The aim of the association is to provide quality care in Ontario's psychiatric facilities and the community for patients and their families. We do this by providing leadership, information and support to the front-line staff in the delivery of mental health care and advocating on behalf of our patients.

We are here today to represent a group of people most of whom cannot represent themselves. To society they are somehow invisible as they sleep in doorways, over subway gratings or stagger through public parks gesturing and talking to themselves. For the members of our group and thousands of our coworkers in the provincial hospital system, they are the people with whom we share our working lives.

To us, they are ill with schizophrenia, manic-depressive illness, dementia and other organic brain diseases. To us, they are people, but people with chronic mental illnesses. So far, these illnesses are only controllable. Cures are rare and prevention very difficult. In the case

of schizophrenia, for example, the illness strikes people very early in life, in the late teens or early adulthood, and if they don't die by suicide or misadventure, they can live to be 65, 70, even 80 years or more. If this isn't a long-term care problem, we don't know what is.

It's true that many psychiatric patients fall through the cracks in the present system. Why? Three reasons: (1) the move to deinstitutionalization that started in the 1960s; (2) the shortage of specialized long-term treatment for them in the community, and driving both of these issues, (3) simply a lack of funding. With the financial cutbacks to the mental health system, those cracks are getting wider.

We're here today to plead strongly on behalf of these people, because despite the focus on long-term care, Bill 173 completely ignores this frail and vulnerable group. Why? Because nowhere in Bill 173 is there any reference to them. It's as if they don't exist.

As many as 40% of the homeless and disfranchised we pass on the street every day have been our patients at one time or another. Like many Canadians who walk by these people every day without really seeing them, it appears that Bill 173 is dealing with them in a similar way: Just ignore them; maybe they'll go away. That's our impression of Bill 173. Nothing in the legislation so far has convinced us we're wrong. I hope we are.

With that background, we begin our comments with a question for the committee's consideration. In the framework statement of the bill, we note there is reference to age, over 65, and to people with physical disabilities. Why are there no provisions for many young adults and adults in midlife who also need long-term care due to their mental illnesses? Some of these illnesses require lifelong or periodic long-term care. We believe these patients should be considered under the bill in much the same way as adults with physical challenges.

Right now, our association's members play a pivotal role in the mental health care of the elderly and others who have severe mental illness. Today, what we would like to do is provide our views on several aspects of Bill 173.

We'd like to start by commenting on the lack of integration between two important reform programs: long-term care and mental health care. Currently there's an important implementation committee working on mental health care called the Mental Health/Long-Term Care Interface Working Group. This working group has recently presented a progress report to the Association of District Health Councils of Ontario. We don't have time

today to present all the issues and questions raised in this report. However, we have attached a copy to this brief and we urge those committee members who haven't had the opportunity to review this document to take a few minutes to look it over.

Generally, the mandate of this working group is to recommend policies and guidelines for the regional and district levels on how to coordinate two service systems for the elderly: long-term care and mental health care. Clearly the work of this group is important for the future, yet the long-term care reforms embodied here in Bill 173 are already going ahead before completion of the mental health reform process, a process which may take five to 10 years to complete.

It may be fair to say that Bill 173 binds all of us working on mental health reform by limiting the possible long-term care solutions in mental health. If Bill 173 goes ahead as drafted, it effectively ties the hands of the interface working group in addressing the long-term care issues of the severely mentally ill and the elderly mentally ill.

As it currently stands, Bill 173 ignores three critical issues: the need for long-term care of the severely mentally ill who are not elderly, the needs of a large percentage of elderly who suffer from mental illness and the need for flexibility during the mental health reform process. We need this flexibility to address the long-term care issues of those with concurrent medical and severe mental illnesses.

Especially in times of economic constraint, no legislation can be successful unless it deals realistically with funding issues. Like many other groups you've heard from, we wonder where the funds are going to come from to support the creation of multiservice agencies and other long-term care initiatives. Even as we speak, funding for health care is already being drastically reduced.

Looking specifically at mental health, funding is going to be cut in three ways:

First, there are expenditure control cuts. At Queen Street Mental Health Centre where I work, a \$7.5-million cut was announced recently. That's about 10% of the hospital's budget. That's 120 patients; 120 patients who won't have a bed if they need readmission. In total, all psychiatric hospitals in the province will have their budgets cut by \$40 million or more. The community mental health sector will see cuts of \$6 million in the next two to three fiscal years.

Second, there are funding cuts coming as a result of mental health care reform. It's been estimated that, over 10 years, the mental health care reforms are expected to reduce the number of psychiatric hospital beds by a further 50%. These are supposed to be reallocations within the mental health envelope, but our experience has been that if the money is cut, we never see it again.

Third, we anticipate reallocations within the mental health budget resulting from these reforms now under way in long-term care. We expect that community geriatric psychiatry services are going to have to be funded out of the present, much reduced, mental health care budget.

In its document *Putting People First*, the government states that no new money will be made available to support mental health care reform. Changes will be made by reallocating resources—money and people—within the existing mental health budget. In other words, will MSAs and long-term care facilities be receiving part of that reallocated money at the expense of the provincial psychiatric system? Yet, according to the present wording of Bill 173, the mandate of these organizations does not include the severely mentally ill. However, at present, it is clear that people with severe mental illness cannot be managed in the long-term care system. This is often why they end up in provincial hospitals in the first place.

Who does have the responsibility for them, and what are the consequences for them and their families with all these current funding cutbacks and future reallocations?

Well, as most of you know, these people may be invisible but they don't just disappear. They go to hostels that bar them after a while because of their agitated or psychotic behaviour. Then they go to the street. Or they end up in nursing homes, where sometimes they have to be isolated or restrained because of their behaviour.

Let me give you an example. Recently, at Queen Street Mental Health Centre, an elderly woman was brought to us from a nursing home. She was very agitated and had assaulted two of the residents of the home. We admitted this woman to the geriatric psychiatry unit. She quickly settled down and her behaviour remained calm. This is not an uncommon occurrence in our psychiatric hospitals. Why? Well, people respond very much to their surroundings. Our hospitals give them a less crowded environment with more personal space. Our staff are trained to deal with agitated or aggressive behaviour. Higher staff ratios mean that patients can be monitored more frequently.

In this environment patients can settle down, but become agitated again if returned to a less supportive environment. This problem can only be resolved by close working relationships between long-term care providers in both the physical and mental health areas. In our view, Bill 173 perpetuates and exaggerates the separation between physical and mental health care. It actually makes close liaison much more difficult.

The Ontario population is aging at a rapid rate; that is clear to all of us. What may not be so obvious is that mental and behaviour disorders are much more common in people with declining health and advancing years. We can expect an exponential increase in these problems in the next 20 years.

The Canadian Study of Health and Aging, a document which is well known to this committee, indicates that 8% of all Canadians over the age of 65 currently suffer from progressive dementia—just one of the mental illnesses associated with aging. The same study estimates that the actual number of dementia cases will more than double by the year 2021 and triple by 2031. In some provincial hospital schizophrenia clinics today, the average age of our patients is between 50 and 60.

Clearly, the stakes are high for long-term care reform for the elderly with mental disorders.

Without dwelling too long on statistics, an appreciation

of the impact of elderly mental health is important in the larger picture of health care reform in Ontario, of which long-term care is a part. Ministry of Health studies have shown that as many as 50% of all hospitalized elderly have at least one psychiatric problem.

The numbers are even more striking in long-term care facilities. As many as 70% of their elderly residents exhibit personality or behaviour problems which may be psychiatric in nature. And as many as 80% have a diagnosed psychiatric disorder.

Our association members are on the front lines of these new, and at times alarming, mental health care needs of the elderly. As these people with mental disorders live longer, we've also had to grapple with the issues of their long-term care. It seems to us that now, when the problem is increasing and placing strains on existing systems, is not the time to radically shift the burden of this responsibility. Nor do we believe it's the time to diminish the role of the trained professional in the assessment, treatment and ongoing care of these elderly patients. That's what appears to have happened by not considering mental health needs in Bill 173.

There have been profound changes in the last 20 years as Ontario's psychiatric facilities have taken a more integrated approach with community-based programs and care. Ontario's institutions have progressively adopted more outpatient and home care approaches, becoming an integral part of the community-based services in their regions.

#### 1020

Over the past 20 years, many of Ontario's psychiatric hospitals have implemented community-based service programs for the elderly. One example is a program at Queen Street Mental Health Centre called PACE, Psychogeriatric Assessment, Consultation and Education. Six other of the provincial hospitals—namely, Brockville, Kingston, North Bay, Penetanguishene, Thunder Bay and Whitby—have similar community geriatric psychiatry programs. In other centres, the psychiatric hospitals collaborate with community-based programs.

Essentially, these programs are geriatric outpatient programs run by the psychiatric hospitals, offering a quick-response multidisciplinary team made up of psychiatrists, GPs, nurses, social workers and occupational therapists. Working with family members, this team quickly assesses the elderly patient's mental health and recommends treatment or, if necessary, long-term care. These programs are accessed by public health nurses, family, friends, family doctors and psychiatrists. Where possible, the geriatric psychiatry team carries out the consultation, assessment, treatment and follow-up in the patient's home or on an outpatient basis.

These special teams are often also involved in assisting the family or patient in accessing other service providers in the areas of housekeeping, housing and specialized professionals. In essence, the community geriatric psychiatry programs have been operation in a multiservice agency fashion for the last 20 years. The PACE program at Queen Street, for example, carries out thousands of in-home visits a year.

These community geriatric psychiatry programs are highly successful and well received by families and groups representing the interests of the elderly. We believe that community geriatric psychiatry programs are the most important building blocks available today in the reform of long-term geriatric mental health care. They have been developed, tested and implemented successfully by highly trained and experienced specialists in mental health care for the elderly. They are based on the principles of family and patient involvement, appropriate treatment and non-institutional care whenever possible.

With that general background on the role of psychiatric hospitals in elderly and long-term mental health care, we'd like now to provide some specific comments on Bill 173.

Our members would welcome the chance to become more involved in the implementation of the reforms proposed. However, to do this in a meaningful way, we feel that the role of psychiatry and the psychiatric system currently in Ontario should be recognized in the bill as a partner and stakeholder in the reform process.

Another general comment on Bill 173 is that we feel it is too restrictive and not flexible enough, especially when it comes to the effects on mental health care reform over the next 10 years.

If this bill is to take us into the next century, then it needs to be more accommodating for change. If you look back 30 years, it's easy to see how wrong we can be in designing mental or general health care for the future. In looking at the objectives set out in the bill, we have some suggestions as to the way in which the mental health aspects can be strengthened.

As explained earlier, seven of the 10 psychiatric hospitals in the province have adopted community geriatric psychiatry programs. Building upon these existing successful programs should be pivotal to the long-term care reform process. Our community geriatric psychiatry programs have treated thousands of elderly with mental disorders, the majority of whom have eventually returned to their homes and families or long-term care facilities.

When we look at the mandate of MSAs, as outlined in the draft bill, we note that mental health and psychiatric care are not even mentioned in the four types of mandatory services to be provided. Yet, the statistics on elderly mental illnesses, provided earlier, clearly indicate that mental health is a major concern with long-term care givers. Indeed, psychiatric disorders are so prevalent that we don't see how this bill can talk about long-term care without talking about psychiatric considerations.

Our association would like to see a clear definition of responsibilities for mental health and how they are to be met. Are psychiatric services to be part of the 20% of purchased services? Are important psychiatric services going to have to fight with other necessary services such as the Red Cross, the VON etc for part of the 20%? Is that what we want to happen? The way the bill reads now, that's the scenario that's painted.

Regarding the bill's objective of improved community-based service system, we have been actively working in this regard for 20 years through our community-based

geriatric programming. However, these programs are not the complete answer.

We believe there must be an understanding and recognition of the role of institutions in long-term care where elderly patients are a threat to themselves or to their families or their community. In these cases the types of treatment, ratio of staff to patients and specialized training needed can only be found in the established psychiatric system.

For many of these patients, the institution is a first resort to long-term treatment and care and not a last resort. For many of the patients I described earlier, the psychiatric hospital is their community, since they are among people specifically trained to look after their needs, and they are with others like themselves.

We need to recognize that for people with severe mental illnesses, the long-term care solutions must involve both the institution and the community, each having its specific role to play, each serving its purpose in a coordinated and balanced way. We wonder how this balance is going to be improved under Bill 173.

In particular, we think our expertise could be invaluable to other long-term care providers in managing mental disorders or behaviour problems. Instead, we feel that Bill 173 will only increase the tendency to dump people with complex problems from one system to the other.

We'd now like to present you some views on how Bill 173 might be improved in order to be relevant to the severely mentally ill community:

(1) That the legislation be amended to include specific references to those with dementia and chronic psychotic illnesses;

(2) That the legislation be amended to allow each community sufficient flexibility to develop and implement a multiservice system to meet its unique needs;

(3) That the legislation be amended to eliminate the four-year deadline so that each community will have the flexibility to develop and implement the best system possible for its long-term care needs.

In closing, we hope that we have offered some insights, raised some vital questions and presented some solutions. We thank you for your attention to this presentation and remain available at any time to this committee for further information or elaboration.

**Mrs Barbara Sullivan (Halton Centre):** I think that this is an extremely important brief and I'm pleased that you've come forward with it.

During the latter part of your brief I've been looking at the progress report to the district health councils on the mental health long-term care interface. What is clearly evident here is that there isn't a structural integration of the two systems, nor of the reform process.

I'm going to ask the parliamentary assistant first of all if, given in the mental health system the reduction in funding for psychiatric hospitals and the reduction that we know from the estimates in community-based mental health funding, and no new money for mental health reform, long-term care is getting some of the reallocated dollars to pick up the slack that will clearly be evident in the mental health system.

Secondly, how do you intend, through this long-term care bill, Bill 173, to deal with the very serious problems of the dually diagnosed, the psychogeriatric population, and not only of those individuals but of the young adults and the adults in middle age who need long-term care because of mental illness?

**Mr Paul Wessenger (Simcoe Centre):** I think what we have to accept is the fact that we are establishing a somewhat integrated system for long-term care dealing in particular with the aged and the physically disabled. I think that's clear. We have many other components of our health care system. We have the acute care system, which again is a separate system. It's not integrated with the long-term care, and the same with mental health, which is also a separate system and has its own reform process being carried out.

That doesn't mean you don't have to have interfaces between the systems. Of course you have to have interfaces between the systems. But, for instance, to suggest integrating the mental health reform into the long-term care reform—let's say it would be a tremendous challenge. We may eventually, in the way our health system evolves, have a total integration, but I think at this stage we have to accept the fact that we're integrating within certain limited services and long-term care is one of these integration areas. At this stage we're not considering any additional integration of specific services.

I certainly acknowledge and understand the concern of the presenters that yes, there has to be an interface between the two systems. But I would suggest that the whole approach on mental health is a separate reform process.

**1030**

**Mrs Sullivan:** I think that it's very hard to justify that argument when you know the level of population proportions that has dual diagnoses, particularly with an aging population to which the long-term care reform is ultimately geared. Furthermore, when you have eliminated the clinician even on the physical side of the problems, what are you going to do on the psychiatric side of illness?

**Mr Wessenger:** I would suggest to you that probably there's as much interface of the long-term care system with the acute care system among people in the long-term care, perhaps more interface than there would be with that and the mental health system. We haven't integrated the acute care system with the long-term care system. To reform a system I think is a basic challenge itself without—and you have to reform a system, I would suggest, before you move to any further integration.

**Dr Jansz Duxszta:** I would like to comment. I believe that in fact there is no integration between the mental health system and the proposed changes, the ones that we're now discussing. Not only that, but while we are proceeding with the cuts, which are not related to the reform in the mental health system, we're taking an incredible risk with what will happen to the people who are under 65 and over 65 in terms of their future admission. It's very easy to discharge someone when the system is not integrated because we expect that someone else will take care of that individual. If that's not happen-

ing they will end up either on the street or with the police.

Unless the two systems are integrated and unless the cuts are actually now stopped, we are asking for an enormous problem. Almost every jurisdiction so far has said there is a minimum of beds which are necessary for psychiatric patients and for the mental health and for the elderly patients, and we have moved towards the cuts which are related to this bill at the moment. That one bill would provide all sorts of services while on the other hand cutting off our ability to provide care both for the mentally ill and for the psychogeriatrics.

**Mr Tilson:** Mr Wessenger simply disagrees. He simply says that mental health is a separate issue. I'm interested in your comments. Just recently you've talked about how right now there are already cuts that are going on. You talk about that \$7.5 million in cuts were announced, about 10% of the hospital budget. My question is, what other social problems, and you're reiterated some of them, are going to be the result of this bill when we know that cuts are going on to the other agencies? In your paper you say that, "Oh well, they'll be sent off to other agencies," but there are cuts going on there. So my question is directly: What other social problems do you anticipate as a result of these cuts?

**Dr Michael Kugelmass:** Already we've seen, because of cracks in the system with current legislation and changes that have occurred over the last number of years—I can give you two anecdotes of things that happened to me yesterday, in fact.

When I was getting on the subway coming to work yesterday morning, a lady got on. With my experience, 25 years of working in mental illness, I think she had a chronic mental illness. She was obviously on the streets because there was nobody to look after her. I've seen her several times, getting on the subway. She was very loud. She was obviously responding to voices, talking about Communist China, Masonic and Jewish plots against her. Of course, she emptied the subway all around her. There's nothing that anybody could do for her and everyone was terrified of her.

The second case was a call I had yesterday afternoon from a daughter of an elderly patient who had been referred to me in one of my other positions as a psychogeriatrician at Wellesley Hospital. The waiting list for her to see me is two months, and she was pleading on behalf of her mother to be seen earlier. I couldn't see her earlier at the Wellesley but I suggested that our PACE program, that you now know about, could see her in her home if she lived in eastern Toronto. Well, she was in Cobourg.

I believe there's another crack in the system in the fact that although we may be somewhat well organized in Toronto, when one gets to the outskirts there's very little help for people. I believe the changes in legislation are not only going to widen and deepen the cracks that exist but they're going to create more cracks.

**Mr Tilson:** You've commented about different programs. You're talking about the PACE program. Do you anticipate that there will be changes to these types of programs as a result of this legislation and as a result of the cuts?

**Dr Kugelmass:** We don't know how the legislation will affect the PACE program. As a result of—

**Dr Duksza:** There are two parallel tracks.

**Mr Larry O'Connor (Durham-York):** You can turn around and ask the minister a question—

**Mr Tilson:** Mr Chairman—

**Dr Kugelmass:** If I may respond to the rest of the question.

**The Acting:** Order. Mr Tilson has the floor.

**Mr Tilson:** I'm directing my comments to you, not to the government members and I suppose—

**Mr O'Connor:** They might like to respond to them.

**Mr Tilson:** You must have philosophized looking at these cuts that are going on along with this bill and what affect they will have on these types of programs.

**Dr Kugelmass:** I can answer the second part of your question, which is the cuts in the budget in the hospital. As far as we can determine, it will obviously create more work for our PACE program. If the budget cuts the PACE program as well, we just don't know the response. We haven't been told that.

**Mr Tilson:** The issue with respect to Mr Wessenger's comments, have you had an opportunity to consult with the government on the views that have been put forward in this paper, any members of you—

**Dr Duksza:** On this bill, no. On the mental health reform, we were included at the provincial advisory committee after pressure on the social contract negotiations. But this is a committee which is extremely large and it's very difficult to get a point across.

In summary, I would say that the professionals who work in the system have been consulted in the most minimal fashion, and these are the people who actually do know what work is done. The consultation has been done generally with a number of other people but not, interestingly—and I will give you an anecdote.

I believe when the provincial advisory committee was discussing questions of retraining and a presentation was made about what kind of training should be done for the professionals who are being let go, which they will be, the committee had no representation from unions or from us and was presented by other people. Yet, it's the people like ourselves, the nurses and OPSEU, who should be directly involved. If we accept the concept of working in the community, they should be directly involved in what kinds of jobs they're going to do and how they're going to be trained to do them. This has not been done.

**Mr Tilson:** That says it all.

**Ms Eklove:** One of the programs of our association is a provincial outreach. Our members have felt so very strongly about the need for consultation and involvement in mental health reform that we have taken it upon ourselves to meet with other stakeholders: other professionals, other patient groups, other family groups that should know about mental health reform. We've met with people in housing, we've met with people in corrections and the police, we've met with people in education, many other professional groups, many of the groups that represent individuals with illnesses, and in all cases there

are grave questions about the mental health care reform and how it will impact on their communities.

**1040**

In some cases, some of the communities had not yet even looked at mental health care reform and how it will increase work or transfer work from the Ministry of Health to other ministries, so it is an issue which continues to astound us at times, that there is a wide range of people who will be affected by this bill who are only now starting to hear about it. We feel it's very important that information get out to them and that they participate with the government as fully as possible to ensure that what is put into place is not going to create more problems.

If I may also make just one point, how important the issue is to us; it happens that today is a board meeting for our association. My colleagues are all doctors in the psychiatric hospitals. For everyone sitting here, there is another colleague in the facility covering for them. They can't leave without the coverage, so what you see here is just a small show of our concern about this issue. In the gallery there are many, many members; in fact, if I could just ask the members of the association to stand up to get a sense of who is here representing facilities through the province.

**Ms Jenny Carter (Peterborough):** Could I have a question of information here, please? There's been a lot of talk about cuts. I was just wondering whether we could have some figures from the ministry as to what is actually happening here, certainly in the community section, and this does concern you when we're talking about the outreach from Queen Street and so on. I understand there's going to be much more funding than there has been.

**Mr Sullivan:** That's incorrect. We dealt with this in the estimates and it is incorrect.

**Mr Wessenger:** We will undertake to get that information for you. While I just have the floor, I might indicate that the MSA will provide information, provide assessments and in addition the MSA will be able to get professional expertise in the psychiatric area.

**Ms Carter:** We're transferring the funding. It'll be there and there will be more of it, right?

*Interjection.*

**Mr Wessenger:** There's no connection between the two.

CHRISTIAN LABOUR ASSOCIATION OF CANADA

**The Acting Chair:** Representatives of the Christian labour association of Ontario, welcome to our committee. I'd ask you to please introduce yourselves and then begin.

**Mr Ray Pennings:** Thank you, Mr Chairman. First of all, a small correction: We are the Christian Labour Association of Canada. That's obviously a typo—that's crept in. My name is Ray Pennings. I'm a national representative with CLAC. Hank Beekhuis is an Ontario representative who works out of our St Catharines office. Ed Grootenboer is our executive director.

As we've all learned over the past number of years,

restructuring an entire long-term care system is no easy task. Ever since the release of a CLAC task force report in 1985 entitled *Serving our Seniors*, reforming and improving Ontario's system of long-term care has ranked among our priorities in representing our members working in the system. Since that time we've seen a steady growth in our membership so that today we are the third-largest union representing workers in the province's long-term care sector.

As a preliminary comment, CLAC supports the objectives of long-term care reform. Coordinating the various services and components of the system and equalizing the funding formulae in order to achieve a more equitable and effective outcome for both care receivers and care providers are worthwhile and, in our view, necessary goals. However, the manner in which one seeks to effect change is as important as defining the objectives, since the long-term care system, like health care in general, very much involves the lives of people, first of all those requiring care, but also those involved in the delivery of care and services.

Given that, our submission this morning will deal with the "how" of bringing about desired reform. In particular, we would like to express our reservations about the multiservice agencies as envisioned by Bill 173, as well as make some observations about the implementation process which followed the passage of the previous phase of long-term care reform, Bill 101, in the hope that the same mistakes are not repeated. We would argue that the structure and conditions proposed for MSAs in Bill 173 will negatively affect the working conditions and choices offered to care providers and will be an inefficient use of taxpayers' money, with resulting negative impacts on the quality of care provided.

At the heart of this bill rests the premise that new government agencies will be able to ensure more efficient and better quality care. This is a premise we would challenge and would like to discuss with the committee. In the creation of the multiservice agencies, we observed the introduction of various rules and rigidities which are likely to be counterproductive. Let us be clear: As we stated earlier, we fully support the objective of long-term care reform, including the creation of one-stop access for the consumer, coordinating the various services currently offered by hundreds of agencies and establishing a minimum basket of services available equally to all Ontarians.

Bill 173 does more than that. It provides not only a single access point for the public, but the MSA will be the only way to access long-term care services. No matter how much stock we put in the community representative boards and how much we legislate respect for linguistic, cultural or religious diversity, the MSAs will govern and direct where individuals will receive care. Agencies and institutions that were established to serve the needs of a particular linguistic or cultural community, a very important factor, particularly for the elderly, or that provide care on the basis of a certain philosophy, will inevitably change or disappear. There is no incentive or structure that will accommodate their continued existence and growth, and that is a loss for our health care system. No single agency, regardless of how community reflective or

well-intentioned it is, will be able to provide the diversity of service which is part of the richness of our current system.

The elimination of the diverse services will occur because of the requirement that the MSA not only ensure access but also deliver at least 80% of the service. This reduces consumer choice. It also places the MSA in an inherent conflict-of-interest position. The MSA will have control over the funds, be responsible for ensuring that regulations are upheld and manage the delivery of service. At the end of the day, all of these functions will report to a single board of decision-makers, who inevitably will have to rely on the professionals who will run the MSA on a day-to-day basis.

By virtue of the provisions of this bill, MSAs are being placed in virtual monopoly positions, responsible for the total delivery of long-term care services. Whenever a monopoly position is afforded, questions of accountability are crucial. The bill before us deals with accountability by instituting an appeal process in part IX for persons who are denied services and by giving the minister revocation and takeover powers in part X. These measures, however, will only deal with extreme situations and, as we've witnessed in the recent crisis at Metro Housing, many people are victimized by a process that has to wait for extreme conditions before remedies can be decided on by Queen's Park.

In an era of fiscal constraint, our members worry that they will be pressured by management in the face of arbitrary fiscal limitations imposed by the MSA to compromise the quality of the service they provide and that there is no effective remedy against this, since the same board that's responsible for defending the quality of their service is also managing the fund and ultimately is their employer.

While Ministry of Health compliance officers may become involved, they have little leverage in dealing with the provider of an essential service who cannot easily be replaced. Today, in the community sector, there is more leverage as agencies depend on annual budget approvals and few are in that monopoly position in providing long-term care.

When our members ask us why the government is proposing to eliminate the various agencies that currently serve the community and replace them with a government agency, we've provided the government's stated rationale: This is supposed to eliminate the duplication of management and overhead costs and increase coordination by placing them within a single agency. The response usually runs something like this: "You mean the government actually thinks that one of its agencies is going to reduce overhead costs by creating a new bureaucracy? By the time they have the directors, communications persons, newsletters and consultants paid for, I doubt a penny will be saved." Call it cynicism if you like, but the reality is that government agencies do not have an inspiring track record in their ability to stretch scarce resources and manage efficiently.

One factor that enters into the government's rationale is its stated preference for the not-for-profit segment of the health industry. As a union, CLAC deals with com-

munity-based, charitable, municipal and commercial agencies. In our task of representing employees, the corporate structure represented on the employer side of the table makes little difference in the quality of care provided. There are those who argue it's inappropriate for health care dollars to end up as corporate profits. While we have sympathy for the argument that public dollars need to be spent efficiently, with value for money, our observation is that as much money is spent profiting management types in some of the so-called not-for-profit sector as it is in the commercial sector.

When, for example, a Revenue Canada taxation form indicates that a single executive officer of a home for the aged received remuneration of \$136,000 in 1991, more than double the average for that position in the private sector, in addition to other perks and well-paid jobs for family members with dubious qualifications, we have little sympathy for the position that the not-for-profit sector is always to be preferred to the commercial sector.

#### 1050

We need to be aggressive in assuring that public funds are not benefiting certain individuals, whether they head up a private corporation or a public board. In our work on the long-term care funding committee, CLAC has worked hard for and supported measures that address these concerns. But the proposition that we need to target the elimination of commercial agencies in order to save the profits for our health system is a red herring argument. In many instances, for-profit institutions deliver as good if not better care in this sector for substantially fewer dollars than the better-funded not-for-profit institutions.

While the merging and amalgamation of various agencies into a multiservice agency will undoubtedly hasten the pace of unionization in the community sector, that does not mean workers automatically will be well served by such a model. Larger units of work organization have not proven to facilitate the choices of workers and the cultivation of a work community. The spectre of a large health care employer and large bargaining units to which all workers belong is a step backwards for plurality and democratic choice, not only for workers, but also for those in need of care. The ability for individuals to make choices and effect change in their local circumstances will be reduced and, in some cases, eliminated.

We submit that the public is better served when different facilities creatively work to solve problems in different ways. In the long term, diversity in labour and other kinds of structures makes us all stronger, as we learn from and build on each other's successes and failures. A single or unitarian system where everything ends up at the board of a multiservice agency concentrates power in too few hands and inevitably leads to unresponsive and bureaucratic isolation from the front-line situations and needs that must be addressed.

In summary, the requirement that multiservice agencies deliver, rather than just provide access to, services has consequences that are detrimental to the delivery of quality long-term care services. This requirement will have the effect of minimizing consumer choice and reducing the diversity of service available to Ontarians,

creating a government bureaucracy that's unlikely to improve efficiency of the system, give rise to employment circumstances where all workers will become employees of large agencies, with the result that individual employees will be less able to make choices and meaningfully influence their work environment, and causing a conflict of interest within the MSA board, which will have to fund, regulate and manage the delivery of services. While mechanisms of appeal are established for those who are denied services, consumers and employees will have less recourse in dealing with quality of service concerns.

These negative consequences stem primarily from the requirement that MSAs deliver at least 80% of the services, as outlined in section 13. If this section were eliminated, there is nothing that would prevent an MSA from delivering the service itself, where that was locally decided to be best, but this should not be a uniform legislated requirement. An amendment to Bill 173 like this would allow for a smoother transition period, greater local flexibility and significantly mitigate some of the negative consequences we've outlined.

It is also important to observe that the accomplishment of long-term care reform needs to involve more than the passage of new legislation to create a new infrastructure; it needs to be matched by the necessary resources to make the changes work. Our members are increasingly becoming frustrated with processes and promises that do not result in real change.

To illustrate this point, we have only to review what's happened since proclamation of Bill 101 in July 1993. One of the major focuses of that bill is to establish a system of funding that would tie funding to the level of care required in long-term care facilities. Many of our members work in heavier care facilities and they looked forward to the passage of this bill, believing it would translate into the much needed increase in staffing levels.

Needless to say, we were disappointed when the first impact of Bill 101 was layoffs in many of the homes that were legitimately expecting increases. In developing the formulae for distributing funds, the previous minimum staffing requirement of 2.25 hours of care per resident per day was tied not to the provincial case mix index of 100, as we had assumed would happen, but to the nursing home average of 110.

The predictable result was substantial layoffs and reductions in hours, which translates into a reduction of care. Homes with higher CMIs, where we expected the hiring to occur, were reluctant to do so because of uncertainty surrounding the then ongoing social contract discussions and the fact that implementation announcements were being made by the minister at the last minute and, in some cases, retroactively. Since service agreements had not been signed designating staffing levels, there was no way to force employers to hire in order to match the funding they were now receiving.

Because of the extensive layoffs and service reduction that occurred, funding was again changed so a corridor was established with the floor CMI of 102 and a ceiling CMI of 116. When this didn't have the desired effect, another change was instituted in December whereby the

minimum staffing regulation of 2.25 hours per resident per day was reintroduced and the floor was raised to 110. This was going to be in effect till March, when we hoped the uncertainty would be cleared up.

A funding working group made up of provider associations, labour representatives and ministry staff worked through the problems and come up with the unanimous recommendation for 1994 funding. Although we were all unhappy with aspects of the recommendation, it was a compromise we all indicated we could live with. The minister chose to disregard the unanimous recommendation which effectively would have bought us a year to deal with transition issues, and the funding work group was briefed on June 1 regarding her decision, which was to have been implemented on July 1.

Because that decision disregarded the careful compromises all sides had made in order to deal with transition issues, chaos ensued. Appeals were made by various groups on both labour and management sides of the table to the minister, the Premier and whoever else would listen. A few days later we learned the latest funding announcement was rescinded and funding was frozen for another year. Since that time, a further change in funding for non-red-circled homes for the aged had to be introduced in order to prevent layoffs.

We should make very clear in all of this that the dedication of the ministry staff who have had to carry this out is unquestioned. They have admirably sought to do a difficult job under very trying circumstances. Thus, in the implementation of Bill 173, the government should ensure that the reform is manageable and the resources adequate to get the job done.

We have experienced that the principal aim of Bill 101 to establish an equitable system of funding tied to the care requirements of residents today is still not a reality. When we explain to our members who ask why their staffing levels have not increased to match the heavier care requirements of their facilities, they only shake their heads in disbelief.

Each of these decisions can be explained and defended in the context of a crisis. An announcement is made. It takes a few weeks for the impacts to trickle down. We frantically look to shift a few dollars from one pocket to another in order to solve the problem. Of course, a few weeks later we find the other pocket short and we start the process again with a new crisis.

The moral? It's fine for the government to proceed with long-term care reform, but this involves more than passing legislation which deals with infrastructure. It requires providing the resources, financial and staffing, so that decisions can be implemented in a timely fashion without endless retroactive adjustments and crisis management decisions. In the context of Bill 173, we need to ensure that reasonable time lines are in place to see measures implemented smoothly. We've already seen confusion in the directions given to DHCs in planning for this phase of long-term care reform.

We need to answer some basic questions: What are the real costs associated with establishing MSAs? Where is this money going to come from? How will this be accomplished within the very ambitious time lines set out,

considering we're talking about the amalgamation, coordination and takeover of hundreds of agencies, involving these agency boards, the DHCs, their long-term care committees and the ministry? Have steps been taken to ensure a smooth transition, or are we on the edge of another logistical nightmare that will make the confusion and uncertainty of Bill 101 look like a cakewalk?

These are not only matters of efficiency and wise spending of scarce dollars. Even more importantly, these matters impact very directly on the working environment for our members and the care that's provided to our seniors. In the midst of all of these discussions about infrastructure, guidelines and regulations, let's never lose sight of the front-line care givers who have the difficult task of providing quality care for those who need it.

**1100**

**Ms Carter:** You're talking about government-run bureaucracies and saying that everything is going to get much more rigid and government-controlled. That doesn't seem to fit the facts, as I have seen them, because what is actually happening here is that administration of long-term care is being handed over by the government to local MSAs, which will have a funding envelope and will have flexibility to use that money for the benefit of the particular people they are serving. Also, MSAs are not necessarily going to be very large. In fact, apparently in Metro one home care program will be replaced by 15 to 20 MSAs, each with a volunteer elected local board.

I'm just wondering what you base this accusation of bureaucracy on. You have also said there will be no choice, and I know it is written into the act that when people are assessed when they are having this interview to find out what their needs are, their wishes will be taken into account, certainly their wishes as regards ethnic, linguistic or whatever characteristics of the institution or whatever that they might be going to. Could you comment on that?

**Mr Pennings:** Gladly. I understand the concern. When you look at the legislation on paper you see the creation of community representative boards with stakeholders and all of these things neatly defined. I guess our concern comes when you talk about—and the point that we emphasize throughout our bill: Why then are the requirements placed in the legislation itself, for instance, that the agency must deliver 80%? If it is true community choice that's going to be made, why can't we leave those sorts of decisions for local boards to implement?

I think the bottom line of all of this, and one can look at the creation of various agencies that currently exist with community representative boards, the reality of the situation is in the field that decisions, even through those sorts of agencies, effectively are controlled by provincial guidelines. One can read the regular long-term care action facts that come from the ministry as well as the guidelines that are produced by the ministry, and one keeps seeing "upon approval of guidelines by the Minister of Health; upon approval"—these things are throughout the whole process.

The point is that these structures will exist, no doubt about it, but the real effective decision-making locus of control is not going to happen at those community

boards, and when we take a look at the track record of such boards and institutions around, I think the evidence bears it out.

**Ms Carter:** I see the provincial guidelines as being more a matter of maintaining standards because, as things are at the moment—you talk about choice but there are a lot of areas in this province where facilities don't measure up to the standards that might be available somewhere else. I'd just like to put it to you that as things are at present, most consumers most of the time do not have choice. Just to take one random example where you might have different home care organizations supplying home care workers for people, I think normally somebody is allocated and I understand that, in one region at least, it depended on which day of the week your application went in where that particular home care giver came from. If you wanted to get the same person a second time, you had to make sure you made the application on the right day of the week.

In the market realm where people are paying for services, then obviously in that sense they have a choice, but I don't think that has been the case otherwise.

**Mr Pennings:** Certainly in this era of scarce resources you're quite right. The choices one wishes were available are not always there because of the funding crunch that a lot of people see, a lot of agencies see. The waiting lists that do exist throughout the province for various services—that is a very valid concern, but the answer to that is to not structurally create a single-access system that is going to control the entire system.

**Mrs Sullivan:** I'm interested in two issues that you've raised, and I'm pleased actually that you raised the questions with respect to worker choice and the units of work organization. Certainly, current theory is that productivity and creativity are increased in a smaller multi-disciplinary environment and it was the first time that point has been raised in our hearings and I appreciated that.

I also want to go back to the issue that you raised with respect to the planning for the transition, and particularly with respect to funding. You have certainly delineated the funding mess that followed Bill 101, and which still continues. I suspect that there will be a funding mess following Bill 173, since first of all, as you pointed out, no one knows the real costs of this implementation.

There are many issues that haven't even been identified beyond identifying the words, and I think one of them is the adjustment issues, the issues of severances and wage parity and pensions for staff people from existing positions who will have to transfer to an MSA, the question of capital assets for existing organizations that may or may not be transferred, any liabilities that the government may face putting businesses out of business, questions of requirements for purchase of either non-mandatory services that are needed to meet a patient's requirements or those services which might be provided by facilities. None of these questions are answered, and in fact they're very much in the dream stages at this point.

I wonder if your organization has looked at various efforts of the district health councils to see if they are coming up with any responses to these kinds of questions.

**Mr Hank Beekhuis:** I think it's sort of interesting that you raise that, partly because of the fact that if you read through the whole Windsor-Essex win-win document, it's very neatly sidestepped in terms of the whole issue of MSAs. They deal very much with the hospital sector.

Once they started the process, they to their horror discovered that instead of the 30 or 40 agencies they thought might be involved in this, in the MSA, that they were up to 230 by the time they were done. I think the logistics of it are scaring everybody off.

For example, you will financially probably use up a tremendous amount of funds just to try to equalize things. Currently there are people out there, and wrongly so in our view, who are being paid minimum wage for the same job that other people are getting paid \$16, \$17 an hour for. How are you going to put that together? There's such a wide disparity out there now that I think we need to take a step back and see what we're doing.

**Mr Jim Wilson (Simcoe West):** Mr Chairman, I know you've indicated you didn't want me to ask a question, but perhaps I could just thank the group for an excellent presentation. I want to say that from the bottom of my heart on behalf of my caucus too, in terms of we've had some submissions from other unions that I don't think, to be very frank about it, they put as much common sense into their submissions as we see here. I think you've given us a very forthright and honest approach.

I want to ask you, just very quickly, if we can't get the government to change its mind about the 80-20 rule and the rigidity in the system and those other things that may make life or continue to make life difficult for the people you represent, should we, on balance, vote in favour of this legislation or not?

I can tell you my experience has been, after three and a half years as Health critic that bills come in and you can tell by the questions from the NDP—we were talking among members last night and we can't remember a time—the people who have been here a long time tell us they can't remember a time when well over 90% of the groups that appeared before this committee in the past few weeks have been opposed to the major technical components and indeed thrust of this legislation. I'd just like your comments on that.

**Mr Pennings:** I'm not going to venture outright and say how you ought to vote, I suppose. But I will say that if the chaos that's going to come out, as I indeed think it is, of the implementation of Bill 173 is anything close to what we've seen in Bill 101, the immediate effects that are going to be felt both by care givers and care receivers are going to be negative, and I think that's a problem.

I think when we look at the overall scheme, we need to address some of the real concerns that Bill 173 is seeking to address, some of the duplication that exists, lack of coordination, lack of single access. Those are very valid objectives, and we can't be silent on that either, and we can't throw out the baby with the bath water. I guess that's where the decision you're going to have to make, as everyone has to struggle in terms of the end, where are the compromises to be decided. But I will say that the

80-20 rule and the process envisioned here, the time-tables, are a recipe for chaos.

1110

#### ONTARIO PSYCHOLOGICAL ASSOCIATION

**The Acting Chair:** The next presentation will be made on behalf of the Ontario Psychological Association. Welcome to our committee.

**Dr Ruth Berman:** I'm Dr Ruth Berman, executive director of the Ontario Psychological Association, and with me is Dr Mary Tierney, chair of our task force on long-term care. As well Dr Tierney is a geriatric psychologist and senior scientist at the Sunnybrook Health Science Centre. We're pleased to have the opportunity today to share our views on Bill 173.

The Ontario Psychological Association is the voluntary organization representing the profession of psychology in Ontario. Our membership of approximately 1,400 includes psychologists, psychometrists and graduate students in psychology.

The Ontario Psychological Association has been an active participant in long-term care reform since 1990, at which time we were invited to have a representative on the long-term care program design advisory group. We have submitted three briefs outlining our perspectives on the care of the elderly and disabled in the province. We also presented our views at another public hearing last March on Bill 101, An Act to amend certain Acts concerning Long-Term Care. The impetus for OPA's involvement has come from our members who work with the elderly and disabled. These members see the need for reform and believe that psychologists can contribute to the health and wellbeing of these potentially vulnerable people.

We acknowledge that the legislation is in place at this time. We understand that the government is attempting to deal with resource problems. As a result, the citizens of Ontario will not be entitled to full coverage of all services available to them. The services of psychologists are among those not included in Bill 173.

The OPA sees merit in long-term care redirection. There is a real need to organize, develop and coordinate services for the burgeoning aging population and the physically disabled. We also agree that there is a need to develop community-based alternatives to institutions and provide support to informal care givers. We see the changes proposed under Bill 173 as an attempt to provide more fair and more equitable distribution of community and long-term care resources.

However, there are some areas within the legislation that require clarification. The compendium to the Long-Term Care Act, 1994, states that the act concerns "elderly persons, adults with physical disabilities and persons who require health services at home." We understand that this would exclude people with developmental disabilities and are uncertain about the inclusion of those with acquired head injuries. Why are these individuals excluded under this legislation and how will they receive services? We believe that these individuals appropriately meet the terms and conditions of the act and their exclusion is most regrettable.

Although we recognize that psychological services have not been designated as a core service in the multi-service agencies, we believe that psychologists can make significant contributions to long-term care given our knowledge and skill.

Psychologists are regulated by the College of Psychologists of Ontario under the Regulated Health Professions Act. The RHPA recognizes the expertise of psychologists by granting them the authority to perform the controlled act of diagnosis in relation to psychological and neuropsychological disorders. The minimum training required for psychologists includes a doctoral degree, typically requiring four years of study after the master's degree.

**Dr Mary Tierney:** Psychologists can assist long-term care patients both through direct and indirect services. In terms of direct services, there are three primary ways in which psychologists can assist the elderly and disabled in Ontario.

First is diagnosis and treatment of mental health problems. It is well documented that senior citizens and the physically disabled, as well as their care givers, suffer from psychological problems more frequently than the general population. These psychological problems arise primarily because of the stress of having to cope with the physical and mental challenges of being disabled or elderly. This stress can affect the individual's health and wellbeing, causing problems such as alcoholism, depression, anxiety, suicide, malnutrition or improper use of medications, any of which can lead to expensive hospitalization.

Even if the physical problems do not lead to hospitalization, the psychological burden on the care givers may impair their ability to cope, leading them to seek hospitalization or institutionalization for their dependent. Moreover, a family member who receives little more than informal support in caring for an older or disabled person is at risk for personal health problems that may in turn result in the care provider becoming the next consumer of formal health care services.

These preventable and treatable psychological problems are often not identified or are misdiagnosed. It has been found that from 40% to 70% of elderly patients' mental health needs are misdiagnosed by the general physician. When they are identified, they often are treated with psychoactive drugs that can have harmful side-effects. Although there is a place for such medication, we know that medication does not provide people with the necessary skills to cope with their problems. Research has consistently shown that coping skills, self-esteem and the ability to exert control over one's life are important factors in illness prevention and in better recovery from illness.

Psychologists are recognized as experts at diagnosing and treating mental health problems. Psychological services will reduce the reliance on psychoactive drugs. These drugs can cause cognitive impairment and can increase the likelihood of confusion, disorientation and, hence, dangerous falls. Both cognitive impairment and falls can increase the risk of hospitalization. The cost of psychological services becomes very reasonable when compared to the cost of acute care hospitalization, place-

ment in long-term care facilities and the direct and indirect costs of medication.

The second area is the diagnosis of cognitive impairment. The elderly are more likely than younger people to show dementia. Unfortunately, many treatable conditions, such as delirium, severe sensory deprivation, anxiety, depression and drug overdose, can be confused with dementia and, if misdiagnosed, can lead to institutionalization and failure to provide appropriate treatment. Accurate and early diagnosis can prevent premature and/or unnecessary institutionalization and enable the best treatment to be provided before the problem escalates. The human tragedy of being misdiagnosed with Alzheimer's disease and placed in a nursing home is a challenge not being directly addressed by long-term care redirection.

The internationally accepted criteria of the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association state that the diagnosis of dementia must be confirmed with a neuropsychological assessment. However, rarely are these psychological services available to the citizens of Ontario unless they are admitted to a chronic care, acute care or rehabilitation hospital that has these specialized services.

Unfortunately, with the downsizing of services in Ontario hospitals, psychological services are becoming even less available to the public. The only other means of accessing such services is on a private fee-for-service basis. The cost of accurate diagnoses of cognitive impairments and dementia must be measured against the cost of misdiagnosis, inappropriate treatment and institutionalization.

The third area is care giver support, and first I'd like to talk about family care givers. Improved support for family care givers is a major goal of long-term care redirection. This change is based on the recognition that families may become overwhelmed and feel their only alternative is to institutionalize their dependent family member.

Research has shown that families institutionalize their dependent member when that individual begins to show dangerous and/or other socially unacceptable behaviour such as physical and verbal aggression, repetitive calling out, wandering, sexual disinhibition and resistance to care. The most frequent manner of controlling these behaviours at home or in institutions is with psychoactive medications, especially neuroleptic or antipsychotic medications.

Besides having to cope with the serious side-effects of these medications, care givers are not typically taught the necessary skills to handle these behaviours in a non-pharmaceutical way. This can lead to a vicious cycle whereby care givers can seek increasingly high doses of medication for the dependent member and thus increase the risk of complications.

Many of these behaviours can be effectively controlled through behavioural management programs. In this regard, psychologists can assist family members by assessing cognitive, emotional and personality functions. Based on these findings, a profile of strengths and deficits can

be provided. Once this is done, the psychologists can then develop a behavioural management plan that considers the profile of the individual and the care givers' abilities and resources. This plan should integrate and coordinate the efforts of all care givers, make specific recommendations for intervention, address recruitment of additional resources and respond to the training needs of the care givers involved.

Next, professional care givers, aides and attendants. Psychologists can help other professionals through the development of behavioural intervention programs to deal with behavioural disturbances associated with dementia and brain damage. Understanding the behavioural implications of neurological damage can help the care giver in anticipating and interpreting many actions of the ones for whom they are caring. Psychologists can train professional care givers and the attendants of the physically disabled in the community to work more effectively with their clients.

**1120**

As you can see, the services of psychologists can be both directly and indirectly provided to the recipients of long-term care redirection. Under the system provided in the present legislation, psychologists can also be valuable assets in consultation on long-term care issues.

First, the bill states, subsection 20(1), that when an individual applies to an approved agency, the agency shall assess the person's requirements, determine eligibility for services, and for each person who is determined to be eligible, develop a plan of service that sets out the amount of each service to be provided to the person. The bill also states that a multiservice agency shall refer a person to other services that may meet the person's requirements more appropriately than the services that the agency provides or arranges.

The assessment of applicants will obviously be an important undertaking for approved agencies. Sometimes the problems and their solutions may be obvious and direct. However, there'll be many applicants whose problems are subtle and difficult to assess before a care plan can be developed. Psychologists, given their expertise in the design of objective behavioural measures, can be of service to the applicants indirectly by working with the MSAs and other approved agencies in developing valid and reliable assessment instruments.

This will assist placement coordinators and agency assessors in accurately identifying problems. It should also improve their ability to develop treatment plans, make appropriate referrals and provide the best placement options. Also, psychologists can help the MSAs in providing guidelines as to when a referral for direct psychological assistance would be appropriate.

In this regard, psychologists could be of assistance to the Ministry of Health in helping to develop criteria for the expenditure of funds on professional services, both psychological and otherwise, when the MSAs cannot meet the needs of the client.

**Dr Berman:** In summary, the OPA continues to support the efforts made and the need for better coordination of services and resources for our long-term care popula-

tion. We very much regret the ministry's decision to exclude psychological care as an essential service under Bill 173 in spite of the ministry's repeated acknowledgement of its value and for the needs of long-term care patients for these types of services.

Bill 173 provides for some, albeit limited, access to the services of psychologists. As such, the establishment of clear and specific guidelines for how, when and for whom such services are to be utilized becomes critical. We would thus strongly encourage this committee to support our recommendation for the establishment of criteria with respect to referral to and utilization of the professional services of both psychologists and other health care providers.

We suggest that this committee consider including in Bill 173 a statutory requirement that the Ministry of Health seek consultation with the professions concerned in order that the necessary and appropriate guidelines might be developed. We thank you for your attention and we'd be pleased to answer any questions you have.

**Mr O'Connor:** I appreciate your presentation today. One of the things that we have heard has been the assessment of the consumer coming into the process. You have mentioned that you are on the design advisory committee, and the questions that I have are, currently today, what is the access point for the consumers that you have; has your association had any involvement with any of the local planning processes through the district health councils; and what has been your feedback to the association from any part of your organization or members that may have been involved in that process in trying to recognize the need for assessment of the consumer group you represent?

**Dr Tierney:** In terms of present access, as we mentioned, the major access is when a person's admitted to a hospital, whether acute, extended care or rehabilitation hospital. Other than that, in the community, really the only way is through pay-for-service. That is done, but obviously that is at a cost to the individual.

In terms of the second question, the district health council?

**Mr O'Connor:** Yes, have any of your associate members been involved with that process?

**Dr Tierney:** A number have tried, including myself, but we've not been invited to be part of the process.

**Mr O'Connor:** In being involved in an assessment, then, at the hospital, which is then the access point, the information that you would gain through the assessment process that you do, would you have a recommendation to people from the ministry that would be taking a look at—I don't know whether you are part of the working group on assessment, but the knowledge that you gain could then be used, if appropriate, for furthering the service of the consumer when they are sent back or returned to the community.

**Dr Tierney:** We aren't part of the working group. We were told that we could be consultants to it, but we aren't part of that working group on assessment.

**Mr O'Connor:** Is there some part of the assessment that you do, then, that would be useful to—what we've

heard in our consultation is the case managers saying, "We're the best person to assess the case and to manage and help to direct appropriate care where necessary." How do you fit into that process? How do you see yourselves?

**Dr Tierney:** We're not saying we should be assessing everyone as they come in the door; what we're saying is that we could assist those who do that assessment in developing a tool that would be useful for them and also having guidelines for when the person should go through a more detailed screen and a more complete assessment. So it's really two-pronged.

**Mr O'Connor:** Is there a follow-up mechanism there that would allow the case manager to have some of that information from the assessment that you've done already so that the appropriate aftercare that may be necessary would kick in, so that the consumer is going to be serviced in the best possible fashion?

**Dr Tierney:** That would be dependent on whether the consumer went to an acute care hospital that had a psychologist who had expertise in the area. At Sunnybrook—and I can only speak for Sunnybrook directly—often the assessments that we do are used, definitely, for placement decisions.

**Mr O'Connor:** So there is a relationship in Sunnybrook with case managers, then?

**Dr Berman:** Oh, absolutely.

**Dr Tierney:** Oh, yes, and in those hospitals where there are psychologists, but that's what we mentioned, that hospitals are being downsized, psychology departments are being hit. It's often said, "Well, go to a hospital, and that's where you'll get that resource," but that resource is just not there any more. So it just won't be available to the public.

VICTORIAN ORDER OF NURSES,  
ONTARIO DIVISION

**The Acting Chair:** The next presentation, please, is to be made on behalf of the Victorian Order of Nurses, Ontario division. Welcome to the committee.

**Ms Fay Booker:** Making this presentation this morning on behalf of VON in Ontario is our provincial executive director, Gale Murray, and myself, Fay Booker, a volunteer in the organization.

VON has been serving the citizens of Ontario since 1897. During this time, VON services have evolved in response to the needs of our communities and have included cottage hospitals, community services such as Meals on Wheels and visiting nursing. At the invitation of the government, VON was the first administrator of the home care program. Over the years, VON has been in the forefront of change in community health. It is from this base of experience that we offer the following recommendations and comments on Bill 173:

(1) The legislation must be flexible enough to allow for different governing and service delivery models to meet the varied needs of Ontario communities while meeting government requirements for accountability;

(2) The legislation be amended to remove the four-year interim arrangement such that federation or coalition models should be allowed to continue if they are proven

to be cost-effective, delivering quality care and giving consumer satisfaction;

(3) The multiservice agencies should be required to provide data on the unit cost of service, quality indicators and consumer satisfaction;

(4) The legislation be amended to allow for consumers to choose the MSA from which they wish to receive services where it is economically feasible to have multiple MSAs;

(5) Evaluations of initial collaborative MSAs be carried out to assess their cost-effectiveness, service quality and degree of consumer satisfaction before requiring all communities to adopt this form of long-term care service delivery.

1130

In regard to flexibility and accountability, Ontario is a large, geographically and culturally diverse province with a complex health care system, including one of the most fully developed long-term community care systems in the country. Such a complex environment requires that the service delivery system reflects the needs of the community it serves and that any major structural change can be proven to be a change for the better. This implies that the legislation directing long-term care reform be flexible enough to allow for this diversity of population and communities.

Bill 173 appears to allow flexibility for the MSA: The MSA must be not-for-profit; the governing body must be composed of consumers and experts in health and social services; the MSA is to be accountable to the community as well as to the minister. VON supports these requirements. Our concern is that while the legislation appears to allow for many different models of governance and service delivery, the comments of the Minister of Health and the ministry staff to the media have implied that just the opposite is true: Only one model for the MSA is acceptable, the one that amalgamates all current service deliverers into one agency. This is not in the best interests of communities which are diverse, and this is not what the communities want or expect, in the view of VON.

This committee has heard from the representatives of many organizations across the province saying there must be flexibility; VON is saying it also, based on our long experience in community health in Ontario. Each of the VON branches offers a variety of services, differing from community to community. Why? Because the needs and priorities of the communities vary.

Our first recommendation is that the legislation be flexible enough to allow for different governing and service delivery models to meet the varied needs of Ontario communities while meeting government's requirements for accountability. All governments require accountability, given the size of dollars spent on the health care system and the importance of this system to the people of Ontario. The question is how this accountability can be best achieved. The legislation proposes to establish independently incorporated, not-for-profit agencies accountable to the community served and the minister. VON supports this approach.

It has been voluntary, charitable, not-for-profit agencies that have developed the long-term care community health care system that is currently in Ontario and which is one of the finest in Canada. Specifically in the areas of palliative care in the home, the utilization of intravenous therapy in the home and innovation in the use of appropriate health workers, such as the homemaker, attendant care worker and the registered practical nurse and registered nurse, the Ontario agencies have shown leadership in continuously improving services and the delivery system.

These agencies have done this under the direction of independent boards made up of community representatives. If there is to be continued accountability for service development at the community level, then Bill 173 must allow the MSA and its board to be accountable to make the decisions with regard to the best structure and service delivery model to meet the community need. If these boards cannot make these decisions, what, then, is the point of setting up a requirement for independent agencies from government?

All governments of Ontario have had a long association with independent, not-for-profit, charitable organizations. The government has on many occasions praised these organizations for their contributions. They have shown accountability by improving the system, as shown by the successful shift of acute care to the community from the hospital, resulting in cost savings to the system and clients more satisfied because their care is at home.

Given the track record of the long-term care community agencies and the current initiatives they have spearheaded to meet the important outcomes of long-term care reform through improved access, better integration of service delivery, development of a chart in the home that all providers can use and a commitment to work on a standard assessment format, VON believes that the legislation should allow this voluntary incremental integration of services that achieves the ends of reform. Thus, the arbitrary requirement that anything less than a full amalgamation of agencies is required for MSA designation and that all interim initiatives have to result in an amalgamated MSA within four years should be withdrawn from the legislation. Rather, the legislation should be enabling, allowing the minister to support new forms of service delivery that meet the goals of reform.

The recommendation is that the legislation be amended to remove the four-year interim arrangement such that federation or coalition models could be allowed to continue if they are proven to be cost-effective, delivering quality care and giving customer satisfaction.

VON has debated internally the proposal for capping the long-term community care budget by de-insuring in-home services. This means that the citizens of Ontario would no longer be entitled under OHIP to such things as visiting nursing. However, the government would be assured of the projected cost of services because of the budget cap.

VON is prepared to support the move from an open-ended health care system to a planned and affordable system. However, we are concerned that this not result in the waiting lists already forecast by the legislation. To avoid this unacceptable feature of a capped system, VON

believes that it is imperative that the reformed system must be adequately funded.

Cost-effective service in turn will come by the government requiring fiscal and quality accountability by developing in partnership with the agencies standards for service cost, quality and consumer satisfaction. These standards should be based on experience and utilize a quality management approach. Agency performance on these indicators should be published both for consumer information and as an incentive for agencies to learn from each other's experience and continuously improve.

We recommend that multiservice agencies be required to provide data on quality management indicators: cost of unit of service, quality indicators and consumer satisfaction.

Given that MSAs will not all offer the same type or level of service outside the core basket of services, in urban areas where it is economically feasible to have more than one MSA, giving consumers the choice of MSA can improve MSA accountability and reduce the occurrence of waiting lists. If agencies know that consumers can compare them based on published data and that consumers can choose to leave one MSA for another, then there is more incentive for the multiservice agency to be cost-effective and avoid the creation of waiting lists. Where it's economically feasible to have multiple MSAs, the legislation should allow for consumers to choose the MSA from which they wish to receive services.

The preferred VON model is a federated MSA. As referenced earlier, the health system in Ontario is one of the best, if not the best, in Canada. The provincial long-term community care system is more fully developed than most provinces, thanks to government and the current agencies' efforts. At this time, there are a number of agencies like VON who have historically been improving the quality, cost-effectiveness and range of services provided. These initiatives were based on community needs and often supported initially by fund-raised dollars. In VON, these initiatives have included palliative care, foot care, volunteer visiting and continence rehabilitation, to name only a few. Our sister agencies have also initiated and financially supported new initiatives.

Today, the long-term care community agencies have been working together to address the long-term care redirection through new proposals to improve consumer access and promote continuity of care. This committee has heard about these efforts in all parts of the province. The common theme in discussions across the province with consumers, communities and planners has been the need to improve the system while building on its current strengths. Let us not throw out all this experience and knowledge gained over the years.

The desired model for the MSA for the most part is a partnership model. The effectiveness of a partnership model can be ensured by having an automated information system allowing comparability of data, having staff on-line to use computers to avoid repetitive data collection and having a common client record system province-wide to promote the exchange of information between MSA workers.

VON is proposing a partnership model because we believe it will allow the outcomes of long-term care redirection to be achieved without destroying the existing long-term care community system. By piloting and evaluating this model as well as others that communities may develop, the government will be ensuring that the citizens of Ontario are actually going to have an improved system at the end of the day.

As was noted in the Hamilton-Wentworth DHC presentation, much research needs to be done in terms of cost-effectiveness, quality and consumer satisfaction. We recommend that evaluation of initial collaborative models of the MSA be carried out to assess their cost-effectiveness, service quality and degree of consumer satisfaction before requiring all communities to adopt a form of long-term care service delivery.

**Maintaining volunteer involvement:** This committee has heard from many, many agencies across the province that currently have volunteers in service delivery and governance roles that they fear the MSA will result in a loss of volunteers to long-term community care. The minister and ministry staff have gone on at great length to reassure that volunteers are not at risk. However, when the experience of Quebec in setting up similar agencies was reviewed in their task force report on health promotion, that is what was found: "Furthermore the government has often been reproached for killing the volunteer movement by systematically paying people in the community to do the work they formerly did without pay."

**1140**

Whether the minister believes it or not, volunteers—and I am one myself, and you have heard from others—are not going to give the commitment of their time and energy and charitable donations to an agency that is perceived to be quasi-governmental.

The minister speaks as if having 1,200 agencies involved today in long-term care is bad. This would only be wrong if it could be shown to be wasteful of the taxpayers' dollars or offering substandard care. There has been no data presented to suggest that this is the case. Rather, in the planning documents and in the government's statements there is acknowledgement of the contribution of these agencies.

This is not to say there is not room for improvement in the system to make it more easily accessible, more comprehensive and continuously improving, both in terms of cost and quality. VON believes that cost-effectiveness can be achieved through better planning between agencies and through the development of common management information systems allowing comparisons between different services. In some cases there can be economy of scale by joint purchasing arrangements and other arrangements. VON itself has used these techniques to improve its outcomes.

After careful review, all of our 33 branches across the province are now meeting with and planning with our partners in the community to achieve the outcomes of the long-term care redirection by building on our shared experience. Some of these interim models are already in place, for example in Windsor. These innovative models are supported by VON boards across the province, but we

are careful to pilot first to ensure that they are achieving their goals. I say this to illustrate that the current volunteers in the system are committed to improving it. Their commitment should be fostered by recognition and respect for an independent but accountable governing structure based on community requirements and preferences.

**Consumer education:** Bill 173 does not directly address the need for well-informed consumers who are able to take responsibility for decisions related to their health and the services required to promote their health and independence, and to use these services wisely. The sections on assessment imply that the consumer will be assessed by a health worker, his or her needs identified and appropriate services provided. This implies a passive role for the consumer.

VON's philosophy of care states that individuals have a primary responsibility for their own health. A primary role of the MSA should be to educate consumers such that they can take up that responsibility. The legislation's paternalistic approach should be amended to one promoting consumer independence and accountability. Promoting healthy consumer behaviour will be as important to the success of long-term care redirection as the restructuring of the system.

Just in conclusion, this presentation has highlighted some of the key issues in Bill 173 from the perspective of VON volunteers and staff across the province. It also reflects what VON has heard from its partners in the long-term care system.

**In summary:**

- There is a need for flexibility and accountability in the MSA structure and service delivery models in a complex province like Ontario if we are to achieve the goals of redirection;

- New mechanisms must be developed to promote cost-effectiveness in the integrated service delivery model replacing brokerage;

- The partnership model utilizing a federated board and geographically based teams should be tested and, if effective, permitted to continue;

- Volunteer involvement requires respect and support for independent, not-for-profit, charitable agencies as MSA partners;

- Consumer education to promote independence and accountability is crucial to the success of the redirection.

VON is requesting amendment to the legislation such that the above issues are addressed. We will be submitting specific suggestions for these amendments to the committee prior to the committee's line-by-line review of the legislation.

In conclusion, we thank you for the opportunity to present these recommendations and to assure you that VON is committed to working with all our partners in the communities across the province as well as government to promote the objectives of the long-term care redirection.

**The Acting Chair:** We have time for one question only. Mr Conway.

**Mr Sean G. Conway (Renfrew North):** I really don't have a question so much as just an observation, and that is that—let me put it in an interrogative form—there's no doubt, then, in your mind, speaking for your organization, that if the bill were to be implemented as now written it would have a very negative effect on the level of volunteer commitment to the long-term care programs that are currently in place?

**Ms Booker:** That's correct. That's our view as the legislation currently stands.

#### REGIONAL MUNICIPALITY OF WATERLOO

**The Acting Chair:** Our next presenters are appearing on behalf of the regional municipality of Waterloo. Welcome to the committee, gentlemen.

**Mr Ken Seiling:** My name is Ken Seiling. I'm the regional chair of the regional municipality of Waterloo. With me is Phil Johnston, who's commissioner of social services, and Kevin Mercer, who's the director of long-term care services. I have provided copies, and I'm sorry I didn't get them to you in advance of today. I've heard many of the comments just in the few minutes I've sat here already, so you're going to be hearing a few things over again.

We feel there's little doubt that reform is needed in this area. In fact our region was one of the areas chosen to pilot the one-stop-access pilots that were attempted and then got lost in the shuffle when governments changed hands and the program passed by the wayside, so we have a long history of involvement in this area.

My comments today are going to focus around the need for continued local flexibility in service management and delivery, the dangers of forcing us to abandon a brokerage model and the inherent difficulties of special-purpose bodies as an administrative structure.

The regional municipality of Waterloo has and continues to demonstrate its commitment and capacity to provide accessible, accountable, quality services that meet the needs of residents. Our extensive history in the planning, management, provision and funding of long-term care services is founded on collaborative, cooperative partnerships with the community which we have been elected to represent. The Social Resources Council of Kitchener-Waterloo, a pioneer in social planning funded by the region and the province, has long been a model for community-based planning. Its joint efforts in many areas with the district health council have proved invaluable in developing community consensus and planning on many fronts.

We are in touch with our community, much more so than the provincial planners in Toronto, and have attempted to bring that knowledge to the table on many occasions. To date, I must admit, much to our dismay, we've had very little success.

The acute home care program was pioneered in Waterloo region by the Victorian Order of Nurses in 1967. With the advent of regional government in 1973 and with the encouragement of the Ministry of Health, administrative responsibility for the program was transferred to the health and social services department of the region. In 1983, the Minister of Health introduced a

chronic home care program to the region as a means of addressing the changing health care requirements of elderly residents. Shortly thereafter, the school health program was added to the health and social services department mandate. Finally, in 1986 the region of Waterloo was selected as the site for the integrated homemaker program. By 1993-94, the region of Waterloo's home care/integrated homemaker/school health budget was approximately \$21 million and provided service to some 3,600 clients monthly.

With the creation of the region in 1973, ownership of Sunnyside Home for the aged was assumed by the region from the county of Waterloo. Over the past 20 years, the role of Sunnyside has evolved to the point where our case mix measure, the measure which addresses level-of-care requirements, continues to increase. Almost 50% of our 265 residents require a significant amount of heavy extended care. Sunnyside has also expanded its services to address the needs of individuals residing in the community through the introduction of the Alzheimer day program and several outreach programs.

Under the authority of the Homemakers and Nurses Services Act, the region purchases homemaking and nursing services for those residents of the region in financial need of such services. While the services under this program declined somewhat as the result of the introduction of the integrated homemaker program, the need for the program continues to be evident both to augment the services available under the integrated homemakers program and to meet needs not eligible for subsidy under the IHP guidelines. In 1994, expenditures for the homemakers and nurses services program are expected to be \$309,000, representing a monthly case load of 100 individuals and families.

Despite the fact that the current government has not included rest and retirement homes in the reform agenda, these homes are viewed by regional council as an important service in the long-term care network. Through 18 purchase-of-service agreements, approximately \$800,000 will be expended in 1994 to provide service to some 200 domiciliary hostel residents.

The region has also contributed for many years towards the cost of home support services for the elderly and physically disabled. In 1994, 10 agencies received \$164,000 in funding towards the cost of meal provision, counselling, transportation, friendly visiting, home maintenance and repairs, to name but a few, and that doesn't include the money donated by the lower-tier municipalities.

Lastly, the region staff and elected officials have worked towards greater coordination and integration of health and social services, greater responsibility for local government to plan, prioritize and manage services and increased communication and cooperation between institutional and community-based services. Specifically, the region has worked closely with the district health council and the social resources council to plan services that meet the needs of local residents. By way of example, the region collaborated with these planning bodies to develop one of the four pilot projects for the government's 1987 one-stop-access initiative. While the government aban-

doned the initiative, the work of the steering committee remains valuable today, and there's considerable documentation on how that would work.

#### 1150

Municipalities are a level of government entrusted with the role of ensuring and improving the economic, environmental, social and public health of the communities municipal councils represent. It is critical, therefore, that the government recognize municipalities as such and not just as another service provider or transfer payment agency. To continue to fulfil its legislated role in the future, the regional municipality believes that the authority and scope of municipal governments should be expanded and not fragmented amongst new local governing structures. This is consistent and supportive of the position taken by AMO in its presentation to you on another day.

Municipal councils must have input into key decisions that determine the quality of life and the economic prosperity of their communities. This belief forms the foundation of the region's mission statement, which states our commitment to advancing the wellbeing of a community in which people want to live and work. Further, we are dedicated to providing quality municipal services delivered with care and accountability. This philosophy is also affirmed in the region's vision for the new official policy plan, which states that citizens will be provided with "...safe, comfortable livelihoods through economic, social and physical development and growth."

Innovations and program planning, management and delivery speak to municipal strengths, such as accountability, responsiveness, flexibility, consultation, collaboration and coordination. Notwithstanding these positive characteristics, we recognize that there are areas that need to be cleared up, particularly as related to unclear provincial mandates and insufficient human and financial resources.

As stated in the 1987 Canadian Council on Social Development report entitled *The Role of Local Government in the Provision of Health and Social Services in Canada*, "...local governments are more likely to provide a quantity and quality of service consistent with the preferences and needs of local residents." The authors also felt that local responsibility for the provision of services has also resulted in greater efficiency in allocating resources because a local electorate is more aware of the benefits and costs of services.

County and regional government structures are also experienced in serving a large and often diverse geographic area. There appears little rationale, therefore, for a proliferation of multiservice agencies within local government boundaries. Numerous examples of the competent and professional administration and delivery of human services such as police services, community health services and social services are evident across the province. Accessible services can be ensured through the establishment of branch offices rather than the creation of several MSAs, each with its own board of directors and catchment areas.

The regional municipality of Waterloo is adamantly opposed to the creation of special-purpose bodies to

assume planning and management roles for health and social services. As stated in the 1970 Waterloo area local government review, the Fyfe report, special-purpose bodies and commissions complicate representation and accountability and cannot be held responsive to or representative of the public as can be a municipal council. That statement is as true today as it was 24 years ago.

There appears little reason, for instance, why the multiservice agency could not be made the responsibility of a committee of council. The regional municipality of Waterloo has a history of utilizing committee structures to advise staff and council on health and social service matters. By way of example, advisory committees have been established to provide advice to staff on the administration and delivery of the home care program at Sunny-side Home. Similarly, the child care advisory committee and a community coordinating committee for Jobs Ontario provides advice to the health and social services committee of regional council on matters pertaining to their respective mandates.

I might add that the Premier himself goes around the province telling how the region of Waterloo is probably the most successful Jobs Ontario delivery program in the province for our success rate, and that is done as an agent of the regional council, not a special-purpose body. So I believe there is ample evidence to show it can work.

One must also question the wisdom of establishing upwards of 40 special-purpose bodies across the province given the associated one-time and ongoing operating costs. Not only will accommodation costs such as furniture and communications networks be required, but support services such as financial systems, human resources expertise and legal services must be provided. There can be little doubt that such costs would far exceed the costs of modifying existing structures. Municipalities, particularly those 30 municipalities currently involved in the administration and delivery of long-term care services, already possess the requisite management resources. Why would we go about recreating them again?

The government has stated that not only will the MSA be a single point of entry for consumers accessing long-term care services, but it will also be a major provider of services required by consumers. Given the fact that the local design of the MSAs is to be based on the notion of flexibility and on meeting the individualistic needs of the communities they serve, the region of Waterloo contends that the government should be willing to consider a brokerage model should this be the community's model of choice. The brokerage model currently utilized by the region's home care/integrated homemakers program is extremely effective from both an administrative and a client service perspective.

From an administrative perspective, the brokerage model allows for the delivery of services by one or more agencies depending on the community need. Accountability of the community is enhanced in such a model through the tendering or purchase-of-service process. Such a process ensures that providers compete for contracts on the basis of price and quality. The inclusion of service standards based on outcomes also permits monitoring and evaluation of effectiveness and efficiency.

Client choice is therefore also safeguarded, a critical factor that service monopoly cannot guarantee.

The vital role of the voluntary sector as delivery agents is also preserved by a brokerage model. And lest you think I'm concerned with the turf war of who's operating, I think here is the crux of where I think it is in our community. Volunteers contribute substantially, both in time and money, many valuable services that form part of the long-term care portfolio. Of particular importance during this time of government constraint are the significant dollars raised through annual fund-raising activities. It is unlikely that this source of program revenue will continue if all services are directly delivered by the MSA. As a result, the government should expect to contribute additional dollars to make up shortfalls in operating costs. A service monopoly model would therefore have a devastating impact on the existing volunteer network and on the cost-effectiveness of many services.

Lastly, a brokerage model spares the expense and effort involved in addressing labour relations matters, an exercise that could become quite cumbersome given the presence of several unions and numerous bargaining units and collective agreements, not to mention the need to integrate unorganized labour into existing staff complements. Volunteers will be lost and wages and salaries driven up needlessly.

In addition to the work of volunteer groups and agencies, I don't believe that the government recognizes or appreciates the amount of non-mandatory, discretionary funding covered by both the region and the lower-tier municipalities. Once the role is taken over by some non-governmental special-purpose body, I don't believe that the optional money and program support now being contributed will continue and it will disappear, together with the work and money of the volunteer sector. As one local health care planner has said, "An avoidance of the municipal contribution appears to be politically unwise and foolhardy."

Let me say it one more time. The regional municipality of Waterloo, in planning partnership with the Waterloo Region District Health Council and social resources council, have cultivated and developed an outstanding capacity in formal and informal long-term care services for the residents of our region. Both lower-tier and upper-tier municipalities, public and private sector providers and an array of consumer-driven advisory committees participate and direct an impressive array of long-term care services which is second to none in Ontario. The MSA concept as currently espoused fails to recognize these involvements and contributions. These thoughtful and sensitive and accessible service delivery arrangements in the region of Waterloo will be placed in peril by the MSA.

To give you some sense of the strength of the feelings in our community, let me reflect on two conversations I had recently with two individuals with responsible roles in the care system of our region. These are both very senior people in the health and social services field, and they described the current proposals and the bill as a form of violence: Violence against the delivery model, which works well in our region; violence against the

groups and agencies which deliver services, whether paid or unpaid; and violence against a community which has worked for many years to build a care infrastructure. The second conversation, which just happened two nights ago, was with a long-time volunteer who stopped me at a reception and pleaded with me to do everything possible to stop the destruction of a system and of the local groups which were so important to the community.

While the regional municipality of Waterloo commends the government for identifying a list of mandatory services to improve accessibility across the province, we are concerned that a commitment to fund these services appears to be lacking. As we have already seen, the introduction of new funding formulas in municipal homes for the aged has had a significant direct and indirect impact upon residents. Specifically, many municipalities have had to increase their levels of funding as a result of red-circling. At a time when the government is seeking higher standards of care, it is failing to provide the necessary financial commitment to achieve the new standards. In addition, staff reductions have occurred and in some instances beds have been permanently closed.

Concern is also raised by the fact that the Ministry of Health is imposing fiscal restraint in the home care/IHP programs for 1994-1995. As a result, it will be extremely difficult for home care programs to meet service demands with funding frozen at the 1993-1994 levels. The waiting list for integrated homemaker programs in the region of Waterloo has already increased from 50 clients a year ago to 114 today. This situation will only deteriorate unless funding levels are restored.

It also goes without saying that if programs are mandated, expensive new bureaucracies established, salaries and wages driven up and the volunteer and municipal contributions undermined without the province being able to fund the results, the new act will see exactly the opposite of that which it was intended to do. It will see the decline of services and the further rationing of existing support. Is the ideological drive for a separate, centralized, controlling agency worth the loss of service and commitment which communities such as ours will experience?

My plea to you today is simple. Please amend this legislation so that it does not destroy the hard work, planning, love, and commitment that so many people in our community have given to the building of a long-term care system. There is dismay and anger within our long-term care community today from those who believe that the government refuses to be flexible and ultimately will drive them from the fields they have chosen to serve. They see themselves and their roles as being altered and destroyed by the direction of the legislation. Please do not allow this to happen. Amend the legislation so that it provides the flexibility for true local planning and delivery.

**1200**

If the decision-making authority is to be at the community level, accountability to the residents of the community must be ensured. Bill 173 as currently written does not enable this to occur. For this reason, the region believes that the bill must be recast so that it recognizes

and builds on existing local government structures. It also believes that the government must recognize that different operational models must be allowed where they will provide for more cost-effective and locally supported services.

In summary, it is our contention:

—That the authority and scope of municipal governments should be expanded and not fragmented amongst new local governing structures.

—That we oppose the creation of special-purpose bodies to assume the planning and management roles for health and social services;

—That the government should be prepared to commit to adequate funding of any service it deems mandatory;

—That legislation should be flexible enough to allow consideration for the continuation of a brokerage model of service delivery;

—Finally, that the government must not allow the destruction of the volunteer and agency components of the current system, which provide much-needed support.

**Mr Tilson:** Your brief is indeed an excellent brief. I have one question and it has to do with funding, which I'm sure you probably anticipate. The government doesn't seem to have any idea what this is all going to mean, notwithstanding it's making major cuts. We've had volunteers come forward and say that they're just not going to exist any more. Fund-raising is going to be down, if not eliminated, notwithstanding the fact the system needs these groups, not only the volunteers but the money, the fund-raising dollars that are raised. Have you put even in general terms the effect this legislation will have financially on Waterloo?

**Mr Phil Johnston:** I'm afraid the answer is no, because it's pretty fuzzy at this point in time. I think all that we have, speaking in an administrative role, is a genuine level of concern. All the signs seem to be danger signs. There are cutbacks occurring already. The chairman has indicated there have been expressions of concerns about the loss of the voluntary sector, which will have to be taken up, I guess, by governmental spending, yet the indications are that such governmental spending will not occur. I think the bottom line for us, and I think it's nicely summarized in the brief, is that the exact opposite of what is intended is likely to occur, that in fact the service levels will drop, not increase.

ELIZABETH LEESON

**The Acting Chair:** Our next presenter is Ms Elizabeth Leeson. Welcome to our committee.

**Mrs Elizabeth Leeson:** Thank you so much. I think I can pretty well represent the age group to keep us out of the old people's home. My name is Elizabeth Leeson, and I thank you for the opportunity to speak. I may say that I do not presume to represent the feelings of people who are terminally ill.

During my working life I was involved with elderly persons. However, not until I became one in that age bracket was I aware of the frailties of the aging process.

In order to become more representative, I have spoken to several older people, ranging in age from 75 to 92

years of age. Married couples to whom I spoke each had been together for more than half a century. They are frail, some with progressive illnesses, but very attached to each other. They manage by just the closeness and caring developed over their lifetime.

One lady wrote to me to say that both she and her husband were diabetic and they tire easily. She has suffered several strokes, and her husband has a form of Parkinson's. They would like to have help with shopping and cleaning the home, including windows and kitchen cupboards. They would be prepared to make reasonable payment for the service. Their greatest wish, however, is to be together.

Single persons living alone in their homes or apartments, when asked about continuing their lifestyle, replied in the same way: house cleaning. They all said they require a little bit of help.

The comprehensive list of assistance listed on page 6 of the bill is excellent. If implemented, it ought to be possible for us to remain in our homes. Our independence and element of dignity is so important.

With the aging process, walking generally becomes slow and muscle power appears to be non-existent. Moving furniture, carrying groceries etc become difficult, if not impossible. Cleaning windows, which involves climbing, is not only dangerous but unwise. If we have always cared for our homes, we continue to do the best we can. It takes much longer, but creature comfort gives us a feeling of contentment. When the task becomes impossible, there is the danger of losing hope. When hope has gone, death is not far behind.

Life must have purpose in order to survive.

In a previous presentation by the Medical Officer of Health for East York, she spoke about the late Muriel Smith. This type of tragedy, unfortunately, is all too common.

Many of us, and I am one, are completely alone. My only child died 13 years ago. Many older persons are alone, not only by death, but are abandoned by their own children. This appalling situation appears to have manifested during the period of the nuclear family.

Dying alone holds much fear for the elderly. At one time, this was unheard of. It is a sad reflection upon society that so many instances of death are not discovered for days or even weeks after life has expired.

I suggest that persons alone in the world or without a support system have a central telephone number. In case of illness, this could be used in order that a home help could be dispatched. The duties of the provider would be to prepare a meal, shopping for necessities or just change the sheets on the bed.

A little bit of tenderness could go a long way in the recovery of the patient. To be sick and alone, not belonging to anyone in this world, is a very frightening experience. There is not much incentive to make the effort to recover.

Furthermore, I suggest a doctor on call could visit the home. The same telephone number could be used for both doctor and help provider.

I do not live in a building solely for senior citizens,

but on one day each week our local Eaton's store provides, free of charge, a transhelp bus to take any elderly persons to the local shopping centre. We do appreciate this service when carrying our groceries. Perhaps other corporate sponsors would be willing to provide this kindness to elderly patrons.

In conclusion, each person to whom I spoke, and I agree, says we ought to pay for whatever service is provided. We wish to maintain our independence for as long as possible. To avoid any abuse of the system and to discourage a further drain on the public purse, payment ought to be mandatory.

1210

**Mr Tony Martin (Sault Ste Marie):** Thank you very much for coming before us today. We've been on the road for a bit now with this piece of legislation, and I personally always find it refreshing, with somebody like yourself, who is obviously a person in a position to make use of some of the services that will be coordinated and provided through this particular exercise of the government, to hear of your thoughts, your concerns and your hopes.

I just celebrated my own mother's birthday on Saturday night in Sault Ste Marie. She turned 79. She and my dad still live together and take advantage of some of the home care service that is available. It allows them to stay in their own apartment unit and, with the help of family, they're able to have a healthy and happy time in their old age.

I guess that's what we're trying to do with this piece of legislation: make sure that everybody across Ontario, in every corner, has access to the kinds of services they need to live a wholesome and happy later period of their lives.

You mentioned one piece where we listed the services re this piece of legislation. Is there anything else in it that you see as helpful re your continuing to live where you do and some of the others like you across the province continuing to stay at home?

**Mrs Leeson:** Well, I've only spoken to people who want to stay in their homes and try to be independent, but we do need a little bit of help. You mentioned your father and mother. That makes all the difference. My only child is dead. My husband is dead. My little grandson is dead. I have two other grandchildren I can't see. I wouldn't know them if I saw them. Apart from that, I'm like the CN Tower: I'm a lone-standing structure without anybody in the world. So we're in an entirely different situation. I just feel that so many people are invisible.

You see, the lady who wrote and told me about her husband and her own situation, they are struggling, because I don't think they know where to go for help. This is why I suggest a central number. I remember Muriel Smith. I didn't know her personally, but I remember the impact, and this is exactly how I feel personally that I shall be found. That's why I ask for a central number; perhaps just someone having flu and you just feel you can't lift your head off the pillow. Phone.

**Mr Gary Malkowski (York East):** Thank you very much for your presentation. Your words are important to

us and your consumer perspective is one that we value.

Talking about the East York community care and some of the services that are provided there, we hope East York will become a bit of a model. If you have any familiarization with what's happening there, could you talk to us a little bit about your own experience as a consumer and what kinds of services you've used?

**Mrs Leeson:** I don't feel that I want any service in particular except that central telephone number and someone to help with the housecleaning.

**Mr Malkowski:** Okay. We hear that loud and clear. That's important to us. Thank you for your feedback.

**Mr Tilson:** Thank you very much for coming.

**Mrs Leeson:** My pleasure, Mr Tilson.

**Mr Tilson:** It's always difficult to come down to these things, I can imagine, and make presentations. You obviously have put a great deal of thought into your presentation and I thank you for that.

My question is that we in our party are opposed to the legislation, if anything because it's going to do away with volunteers; it's going to do away with volunteer fundraising. In your position, will you be able to manage alone?

**Mrs Leeson:** I don't know for how long I shall be able to manage alone, for the simple reason I have nobody. I have no support system whatsoever. But I know definitely I do not intend to enter a senior citizen home, not while I am compos mentis. So the only thing that comes when you can't manage is just give up. But each day I live in the hope, and this is the one thing that does keep me alive, that my grandchildren will realize they do have a grandmother and I shall see them before the end. That's the only thing that keeps me going.

**Mr Tilson:** Thank you very much. We need personal stories such as yours to come and assist and hope that the government will listen to some of you—

**Mrs Leeson:** Well, I've tried for many years to get the government to listen, but if Bill 124 had been proclaimed and if they had had three parties agree on that bill, if it had been proclaimed, it would have made all the difference in the world to a great many people, and I am one.

**Mr Tilson:** That's Mr O'Connor's bill.

**Mrs Leeson:** No, that was not. That was Mr Scott's bill, when he was the Attorney General.

Much more emphasis must be given to the people who want to be independent and need that little bit of help, because you see, we go back a very long way, when we did our washing, our cleaning and everything with an element of speed. There weren't the material things that we have now. We want to keep that standard and it's very, very difficult.

Furthermore, if you put on housecleaning and different other services for the community of older people, it could provide a great many jobs, because everyone does not want to be professional. Lots of women and men like to do housecleaning, and if properly trained, it could create a great many jobs. But just give us our independence and a little bit of encouragement. That's all we want.

**Mr Tilson:** Mrs Leeson, thank you very much for coming. Your comments are greatly appreciated.

**Mr Conway:** Mrs Leeson, I want to join my colleagues in thanking you very much for a very good presentation and a very strong defence of your point of view.

**Mrs Leeson:** I'm in the age bracket that I know what it feels like.

**Mr Conway:** I hear you loudly when you say you do not want to go to a home if at all possible. Just one of the things I'm interested in, from your experience personally and with any of your friends—I think members of the Legislature of all sides are really concerned about elderly persons who are alone and don't have the kind of support system that I think we would all like to see in place. In your case, you've got grandchildren. You live in Metropolitan Toronto.

**Mrs Leeson:** I wouldn't know my grandchildren if I saw them. When my daughter died, I was shut out, like thousands of other grandparents in the same position.

**Mr Conway:** That was my question: the role of family in a situation like that. In your personal case, your relationship with your grandchildren is not—

**Mrs Leeson:** I fought for 12 years through every aspect of the law to see them, and eventually in Newmarket court on March 15, 1993, I was treated like a criminal and forbidden to make any further effort to even communicate or send them a Christmas card.

**Mr Conway:** Thank you very much.

**The Acting Chair:** Mrs Leeson, a very special thank you for taking the time and making the effort to come down and speak with us here today.

**Mrs Leeson:** Thank you so much.

*The committee recessed from 1218 to 1408.*

KIDNEY FOUNDATION OF CANADA (ONTARIO)

CANADIAN ASSOCIATION OF

NEPHROLOGY SOCIAL WORKERS (ONTARIO)

**The Chair (Mr Charles Beer):** We'll get under way and we will call our first witnesses, from the Kidney Foundation of Canada (Ontario), if they'd be good enough to come forward. Welcome to the committee.

**Ms Janet Bick:** My name is Janet Bick and I'm the provincial advocacy coordinator with the Kidney Foundation of Canada (Ontario).

**Ms Lisa Bletcher:** My name is Lisa Bletcher. I'm a renal social worker at Credit Valley Hospital in Mississauga and I'm here representing the Canadian Association of Nephrology Social Workers (Ontario).

**Ms Bick:** Good afternoon. We appreciate the opportunity to present our views on Bill 173 today. As I think a lot of the members of this committee are quite well aware, at present there are over 6,000 Ontarians being treated for end stage renal disease in the province. The greatest increase in that renal failure population is among the elderly, who make up the bulk of those individuals who are using long-term care services. The members of this committee will be quite familiar with a lot of the other issues regarding renal care as a result of the study that was undertaken by this committee last April.

The Canadian Association of Nephrology Social Workers and the Kidney Foundation support the goals and objectives of the long-term care reform. Like most health care recipients, individuals with kidney failure would almost always choose to remain in their own homes with appropriate support services rather than be in an institutional setting. Renal patients have always been at a disadvantage with regard to long-term care services. Often their needs cannot be met in either a community or institutional setting due to a lack of appropriate services, restrictive eligibility criteria and a lack of understanding of their particular needs.

Of course, the reasons for this situation lie somewhat within the scope of long-term care reform, while others of those difficulties will require changes in the way health care is delivered to these people.

The objectives of Bill 173 are admirable and we certainly would be pleased to support a well-funded, well-managed system that would allow people who require health care and support services to stay in their own homes for as long as possible. We certainly recognize that that's really the most cost-effective way of meeting their needs, and that certainly is true of the renal failure population.

We've identified a number of areas in the legislation which we believe require more detail to ensure that the goals of the act are met. I would like to pass the microphone to Lisa, and she will provide you with an overview of those recommendations.

**Ms Bletcher:** As you will see in our written submission, the CANSW and the Kidney Foundation have offered six recommendations. I will refer to each one, but I'll focus mainly on recommendations 2 to 5 because I feel they need more explanation.

Recommendation 1, which refers to the bill of rights: Bill 173 should be amended to include a specific requirement that all information must be provided to clients in plain language and in accessible formats.

We support the bill of rights, as it affirms the rights of the client to receive information on community services, information on laws, rules and policies and information on the complaints process. However, because many renal patients are visually impaired due to the fact that many of them are diabetics, and because the renal population is multicultural, with many patients unable to speak or read English, the information must be available in an accessible format; for example, if we could provide the written information in various languages or provide audiotapes, or even if interpreters could be available when we pass this information on.

Recommendation 2, access to services: Qualifications and staffing levels appropriate to the services the MSAs are required to provide should be clearly specified in the regulations, as well as a clear set of guidelines for the sharing of the assessment and resource education roles between the MSA and hospital social workers who are already providing service to the clients.

Currently, renal social workers are providing many of the services outlined for the MSAs. Actually, we sort of referred to ourselves after we read this as the mini-MSAs.

The services that we provide already are assessment of patient needs, provision of information to patients and families regarding what community resources are out there, sharing the information regarding what the eligibility criteria are, referral to these resources and services and follow-up.

Linking renal patients up to available community services actually works quite well at present because these patients have access to renal social workers and we are attached to the hospital renal program. The renal social workers' understanding of the needs of their patients, their knowledge of the community resources and their easy access to other members of the health care team make for a quick referral process. The question is, what will happen when the MSA staff becomes involved?

The legislation does not address the procedural aspects of these functions of the MSAs, nor the qualifications of the MSA staff providing assessments and information. A number of concerns arise from that: the duplication of service; increased paperwork that may cause delays in timely access to services—actually we're already experiencing that with the passage of the Long-Term Care Statute Law Amendment Act of 1993, where the placement coordination service is taking on more tasks, so they have many, many forms to be filled out now; third, the creation of another level of bureaucracy; fourth, the ability of the MSA staff to make a valid assessment based on a one-hour hospital or home visit; and fifth, possible delays between referral and initiation of service that will lead to delays in hospital discharge.

Recommendation 3, mandatory services: The mandatory services provided by the MSA should be clearly defined in the legislation if the goal of bringing consistency to service delivery across the province is to be met. The definition should specify which services will be subject to charges.

Providing the MSAs with a list of mandatory services is important, but if the services are not described in more detail, each MSA may define them differently. It's not clear, for example, whether assistance for peritoneal dialysis exchanges would be considered a professional service or a personal support service. Will a nurse have to provide this service or could an attendant care or homemaker provide this service?

In terms of transportation—this is also an example—will MSAs actually work with a client to set up a regular transportation schedule for treatment in clinics and will they also follow through with making sure the transportation will continue?

These are the kinds of questions that need to be answered.

Recommendation 4, eligibility for services: The legislation and regulations have to provide MSAs with the flexibility to do creative problem-solving to meet the needs of renal patients, who do not always fit neatly into prescribed eligibility criteria. Under the current system, many renal patients fall between the cracks due to eligibility criteria that are not sufficiently flexible to accommodate a particular situation.

For example, the integrated homemaking program,

which actually has been very beneficial, requires that the client needs help with personal care, whereas many renal patients only feel comfortable with a family member providing this personal care. But then they do need assistance with housekeeping tasks, as the family member cannot do it all. Another example is the renal patient who is not eligible for the regional respite program, as it is only for the memory impaired. So of particular concern are those patients who do not fit into a single category like seniors, the developmentally handicapped or the one that I've already mentioned.

Recommendation 5, availability of services/waiting lists: The legislation and the regulations should establish a system of priorities for waiting lists and priorities for services which are provided to individuals who depend on life-sustaining treatment such as dialysis.

The legislation requires that services be delivered in as timely a fashion as possible but does acknowledge that services may not be available. This results in waiting lists. There's nothing in the legislation that permits the prioritization of individuals on the waiting list or between services provided.

For example, if the amount allocated for community nursing services for dialysis patients is reached and a waiting list is created, money cannot be shifted from another area to provide additional services. The individuals on the waiting list would be forced to continue to occupy expensive acute care beds in the hospital or switch to haemodialysis, which is a more costly type of treatment.

The last recommendation, 6, regarding the regulations: Key regulations such as those governing assessments, determination of eligibility criteria, definition of the nature and amounts of services that may be provided should be drafted prior to third reading and available for public input.

Due to the broad regulation-making power that the legislation permits, it's very difficult at this point to determine whether or not the MSA system will really mean improved availability and access to appropriate long-term care services for the renal population. We feel that the public needs more input prior to the third reading so that the interests of the current and future clients of long-term care services will be taken into account.

#### 1420

I'd just like to make reference to a couple of case examples in appendix C. I don't think I will read them out, but I just was hoping that people would refer to them. These are two of many I could have come with, but both of these cases serve to illustrate the difficulties renal patients have in attempting to remain in their own homes. There's no question that they choose to remain in their own homes in most cases, but too often they're forced to switch to a more expensive form of treatment or be admitted to acute care beds in order to be able to receive treatment. They point to the need to make eligibility criteria more flexible and to provide adequate funding to community services to provide the assistance that these individuals require.

Thank you for giving me this opportunity. It's hoped

that you'll consider these recommendations when you proceed to examine the legislation.

**Mr Jim Wilson:** Thank you very much for your presentation, Janet. It's good to see you again. You're becoming a regular contributor to the social development committee. Lisa, we certainly appreciate the input from renal social workers. We've had no one from that profession to date appear before the committee specifically with renal care in mind.

I agree with a number of things. I should say, I guess, from the work this committee's done and the work members have done, that I certainly agree with your latter comments, Lisa, in terms of the general feeling I find with dialysis patients, particularly haemodialysis patients in my own area. They would just like the service as close to home as possible, not necessarily in their homes, although we're having great success in my local area in getting a number of machines in homes. We'd frankly like a satellite so we could share those resources with those who haven't been fortunate enough to get a machine in home, but that is a subject for another day. Hopefully soon the Central East Study Committee will be reporting back to the Legislature and we'll have some more progress on the dialysis situation.

Specifically, I know it's your last recommendation, but I think it's quite key, and that is with respect to regulations so that we know what we're talking about in this bill. You started off the presentation saying what a number of us would agree with, and that is that the principles seem great, the bill of rights seems great. However, I'm not convinced, after over two weeks of public hearings and dozens of meetings, that the legislation as drafted meets those principles and meets the government's own tests for an effective piece of legislation that would indeed enhance long-term care services in the province.

When asked yesterday about regulations, the parliamentary assistant indicated they hadn't written any yet, which I found pretty astounding, that they would want us to vote on third reading without knowing what the recommendations are. In fact, I don't think that was a complete answer from the government.

My question that I'm going to direct to the parliamentary assistant is one that you ask, and that is, how are waiting lists to be handled? Waiting lists are a growing problem in the province and will be more so, I think, because we're going to spend millions of dollars in administration with MSAs. During the next four years, I think, there's going to be less money for front-line services and more money for bureaucracy.

Will there be rules, Parliamentary Assistant, or guidelines, or what is the current thinking of the government with respect to how MSAs will be directed to deal with the waiting lists which I believe are inevitable with this legislation?

**Mr Wessinger:** The legislation clearly sets out the ability to make regulations with respect to prescribing rules for waiting lists, including ranking them in terms of their priority. So in reality, that will continue to be a needs-based situation with respect to setting priorities. That will continue to be so.

While I have the floor, there's one other item that was raised that I don't know whether you'd like to deal with at this time—

**Mr Jim Wilson:** Could I just touch that point—

**Mr Wessinger:** —the other question on the transportation issue.

**Mr Jim Wilson:** Just with respect to that, though, if you're going to be making regulations after this thing leaves Parliament and leaves this public forum, what input would groups like the Kidney Foundation and renal social workers have into that? Is there some committee they should be on now to advise you on that?

**Mr Wessinger:** I'll ask Mr Quirt to indicate the process with respect to regulations.

**Mr Geoff Quirt:** At this point there are about 11 working groups with representatives from various consumer and provider interests that are helping us in the program design stages to develop a program manual for multiservice agencies that will address the issue of who's eligible for how much service and how best to manage those services within a defined budget.

As you know, there are waiting lists now. The only solution to eliminating waiting lists would be to have an unending supply of funding, and home care programs do a good job now of managing their resources and making sure that emergencies are taken care of and that resources are used appropriately.

We want to make sure there's a capacity to deal with emergency situations as they come up, and the prioritization of clients is one of the topics for discussion at that working group level. If you're not involved in those working groups, we'd certainly like to talk to you about your interest in them and find out the most appropriate way for you to make input specifically with respect to the issues you've raised in your brief.

**Mr Jim Wilson:** Is that a commitment that you'd like followed up with, Mr Quirt?

**The Chair:** There's an offer there.

**Ms Bletcher:** Definitely.

**Mr Jim Wilson:** I'd like to make sure the offer's followed through. I take Mr Quirt at his word.

**The Chair:** I think a lot of us heard it, so we've got—

**Mr Jim Wilson:** We've heard a lot of things, Mr Chairman, in the last four years.

**The Chair:** The parliamentary assistant had a comment on one of the other issues that you raised.

**Mr Wessinger:** The other comment you made is you said that the legislation does not specify what transportation services are to be provided. It does, and I'll ask legal counsel perhaps to indicate the details of that.

**Ms Gail Czukar:** I just wanted to point out that transportation services are defined in the bill. They include both assisting people to use existing transportation where that's the need or to use alternate transportation where they're not able to use existing transportation. So I think the answer to the question in the brief about working with the client to set up regular transportation schedules and so on is yes.

## AFRICAN CANADIAN ENTREPRENEURS

**The Chair:** I call on our next witness, from the African Canadian Entrepreneurs, Ms Delores Lawrence, president. Welcome to the committee.

**Ms Delores Lawrence:** Thank you very much for allowing my organization to do a presentation to the committee this afternoon. You all have in front of you a copy of my talk which you could follow with me or you could ask me questions after. I'll certainly leave ample time for that.

Just a little background on the African Canadian Entrepreneurs, otherwise known as ACE. We were incorporated in 1993. We're a not-for-profit organization, and our goal was to support the economic and political empowerment of African Canadians. Our membership includes all African Canadians who are currently entrepreneurs in Canada and those who support the goals and objectives of ACE. By African Canadians, it encompasses those who are born in Africa, the Caribbean, Europe, North and South America. ACE is governed by a president and a nine-member board of directors who are elected for two-year terms.

The issues that are before us that bring us here today are that the Minister of Health has released Bill 173, the second bill related to reforms of the long-term care system. This follows Bill 101, introduced in November 1992 and passed in June 1993. The long-term care system in Ontario is a system providing health and personal support services to seniors and people with disabilities. The main components of the bill are the introduction of the bill of rights and the tool of multiservice implementation agencies, otherwise known as MSAs.

Whereas Bill 101 focused primarily on institutional care in nursing homes and homes for the aged, Bill 173 deals mainly with services that are provided by community agencies. This will ensure that people remain at home or in their home communities for as long as possible. In other words, institutional care is being delayed.

1430

Currently, there are several providers of different types of services such as nursing care, physiotherapy, speech therapy and personal support services; for example, assistance with activities of daily living, which includes bathing, dressing, cleaning, shopping, laundry, and bill payments, to name just a few. These are available to seniors and to the disabled in Ontario.

Over the past few months, as president of the African Canadian Entrepreneurs, I have attended seminars, workshops and information sessions sponsored by the Metropolitan Toronto District Health Council, which established a committee in April 1993 to look at MSAs in Metropolitan Toronto. Several factors should be taken into consideration.

The size and the diversity of the population of Metropolitan Toronto are unique in North America. One of the concerns is, how do we ensure fair and equitable access to services by all ethnoracial communities? There is no doubt that all the MSAs should be reflective of the population in Metropolitan Toronto and equitable.

How do we ensure that the large number of volunteers

who have historically played a significant role in planning and funding continue to do so? Millions of dollars have been generated by agencies and community-based fundraising projects. How do you ensure that this will continue?

The Ministry of Health has decided to impose restrictions on agencies that do not become part of MSAs. This no doubt will mean the loss of thousands of jobs both in the private and non-profit sector. Section 13 of Bill 173 limits the amount of service an MSA can purchase from any agency, private sector or otherwise: no more than 20% of all the home care services being provided by the MSA. The government had planned to limit only the commercial sector to 10% or less. However, when the legislation was introduced, the government extended the ceiling to include all providers who are not part of the MSA.

Private sector companies face a crisis situation. More than half the commercial home care agencies in Ontario account for almost 50% of the services provided in Ontario.

What does the future look like?

There is no doubt that if the commercial agencies go out of business, the employees will also be unemployed. This is not encouraging news.

Many home care workers are minorities and women. How can these laid-off workers be guaranteed jobs when the government made commitments during the social contract negotiations to fill new jobs in the health care system with unionized hospital workers who were laid off? This means squeezing out this disadvantaged group.

What about the severance packages? Does this then mean that they are sent back to the social welfare system?

This bill is a bill about not just long-term care reform, but killing entrepreneurship in health care and killing jobs. Home care workers no doubt await the same fate as their colleagues in day care, whom the NDP government cast aside without any support or any bridging of benefits for seniority.

In conclusion:

It is encouraging to see the introduction of the bill of rights and we support its inclusion in Bill 173.

MSAs should be the coordinators of services rather than the coordinators and deliverers of services.

The bill should not eliminate individual charitable structures currently in place. The uniqueness of ethnoracial communities definitely is a plus when it comes to fund-raising. Will the government make up the difference in lost fund-raising dollars?

It is important that consumers have a choice. By limiting private sector to 20%, there will be no choice.

With the government running MSAs, it does not mean that efficiency will be increased or delivery of care will be more cost-effective. In fact, competition keeps costs down and is reason enough not to limit private sector to 20%. Do not create a monopoly, but provide the most cost-effective approach to health care to the people of Ontario.

**The Chair:** Thank you very much for the presentation. Just before going to questions, I remind committee members and also those who are with us that because of the number of individuals and groups that have asked to appear before the committee, in trying to ensure that we hear from everybody who has asked to come, we have to limit our questions to one with each presenter. The fact that there is only one question does not mean there isn't a lot more interest, but I'm afraid we had to make the choice between ensuring that we heard the views of those who wanted to come before us or listening to ourselves, and we get to do that so often in the Legislature that we thought this was perhaps the fair compromise. With that in mind, on the rotation the question is with the NDP and Ms Carter.

**Ms Carter:** Under your heading "The Future" you say that under Bill 173 there's going to be a lot of unemployment of people who are presently employed in home care and so on. I just want to challenge that, because I think actually what we're looking at is a big expansion of services. Although many areas in Ontario have had very good services, there have been other places that haven't been so fortunate. There have been gaps, and what we're trying to do is to spread those services all over the province so that everybody will have the essentials. Actually, there is a large increase in jobs available, and I believe there have already been thousands of extra workers employed in home care. Maybe we could have some figures on that.

**Mr Wessinger:** I'll ask Mr Quirt to provide that.

**Mr Quirt:** We can estimate that with the investment of \$441 million in new programs and services throughout the entire length of the redirection budget—we're about halfway through now; we've invested about \$250 million and there's another roughly \$190 million to go—thousands of jobs will be created. Our estimate, for example, with the implementation of the integrated homemaker program, based on the number of workers and their wages and the number of full- and part-time jobs in the system now, is that 5,000 jobs were created with the introduction of the integrated homemaker program alone. We hope that as a result of the redirection there will be many, many more jobs added, and as has been noted earlier, mostly in the direct service area as opposed to administration.

**The Chair:** Did you wish to comment?

**Ms Lawrence:** Yes, I would like to comment on that. When the government had made the social contract commitment, I'm sure many of you are aware that there are many hospitals that were doing things as simple as laundry, and the laundry department has been eliminated. A lot of displaced workers are out there at this time. If the current home care situation in Ontario is you have about 50% of the market now with the private sector, how can you—I'd like to see some research that would show that those jobs would in fact be re-created. What would be happening is that there would be an awful lot of people out there without jobs if the displaced workers in the institutions are used first.

**The Chair:** Ms Lawrence, thank you for coming before the committee and raising the issues that you have.

1440

## REGIONAL MUNICIPALITY OF YORK

**The Chair:** I call on our next presenters, from the regional municipality of York. The committee is always thoroughly delighted to have representation from the region of York.

**Mr Eldred King:** It certainly is our pleasure to appear before you on this very important issue. I will introduce the members representing the region of York: Mr Bob Scott, a regional councillor from the town of Newmarket who chairs our health and community services committee; Dr Helena Jaczek, medical officer of health, region of York; and Mr Peter Crichton, the commissioner of community services.

Charles, I'm delighted to hear you say that you are delighted that you have guests from York.

**The Chair:** We have both quantity and quality when York comes forward.

**Mr King:** We'll agree with you.

**Mr Tilson:** Let's not overdo this.

**Mr King:** No, let's not overdo it. Let's not forget about Peel.

We are here today to express to you our very grave concern with Bill 173, An Act Respecting Long-term Care in Ontario. We have in York region been a partner in providing health, social and support services to senior citizens and people of all ages in our community for more than 20 years. We are completely mystified by a provincial government that proposes legislation such as Bill 173, an act that ignores the existence of regional government, a tier of government which was originally created by the province of Ontario, and that minimizes the value of long-standing community-based volunteer organizations and creates a whole new bureaucracy for the taxpayer to support.

We have a presentation to make today on what we specifically object to in this act. We shared this presentation with our planning and service delivery partners in the community on August 17 at a special meeting, and although you will hear or have already heard from groups in York region who support our position, there has not been sufficient time for us to fully consult within our region. I would add that I don't believe there is sufficient time for anyone with the responsibility that has been placed on the district health council to fully respond to the impact and implementation of the intent of the act.

We would very much like to have the time to explore a regional management model and to reasonably discuss the appropriate governance of a multiservice agency with all stakeholders in York region. The question of governance is very much in the forefront in these days when the cost of supplying services and the duplication of supplying those services is so very evident.

I will ask Mr Crichton now to present our position, and Dr Jaczek will also assist.

**Mr Peter Crichton:** We are here today to express the regional municipality of York's concerns regarding the establishment of a new non-profit agency to provide long-term care services in the community, and to request a

change to section 13 of Bill 173. This section limits purchase of service outside the multiservice agency to 20%. We believe a change is necessary in order to preserve an individual's choice of preferred service provider, as well as to provide communities with greater flexibility in designing the multiservice agencies. We are also here to request a change to subsection 11(3) of the legislation to give municipalities the first option to be designated as an approved multiservice agency.

We urge the government to delay the implementation of Bill 173 while a thorough review of the issues is undertaken. We note that these issues and others have been raised consistently during these hearings.

We are in full agreement that access to long-term care services for senior citizens and the physically disabled in the community had to be simplified. We recognize that previous provincial governments have made attempts to consolidate program delivery and funding rationale. We recognize the effort made by this government in continuing to reform the entire system of long-term care services in Ontario to ensure that coordinated and integrated care is accessible to all. We also acknowledge that the task has been made more difficult by financial constraints that have impacted our communities and our families in unprecedented and drastic ways.

As public service providers, we are increasingly aware of the transformation that has already taken place in moving from facility or hospital care to community-based home support systems. We wish to emphasize to you the responsibility that municipalities have towards the provision of community support services. Municipalities view these programs as major public services. We support the continuing trend towards community-based long-term care services and we also believe that such services should be viewed as a major public utility.

**Dr Helena Jaczek:** For these reasons, we suggest to you that the model of a multiservice agency, as proposed in Bill 173, has a number of flaws. We have two major concerns.

First, consolidation into a single provider agency: The requirement that 80% of long-term care services in the community must be provided directly by MSAs creates a single service provider that has a virtual monopoly on the delivery of a major public service. While perhaps appropriate in small rural communities, this will not necessarily improve service in more urbanized areas with many existing agencies and a diversified population.

We are very concerned that detailed cost-benefit analyses have not been done. While savings may be achieved in the short term by consolidating administrative functions, the long-range cost-benefit is questionable, given the magnitude of program delivery, the areas of specialization that will have to be developed and the size of the supporting organization that will be created. Further information on base budgets and ongoing funding proposals for MSAs should be released by the government and included as part of both the communities' and the provincial review processes.

We have a great deal of concern about the future of many community-based agencies, about preserving the character and expertise of these existing agencies. We are

also concerned about the continued commitment of volunteers and the loss of charitable contributions to a service provider that is viewed as a large bureaucracy.

Our second problem with the bill as it stands relates to definition of governance models that do not recognize the role of regional government.

The MSA will become the provider of a major public service, but will be accountable only to its board and the provincial government. The guidelines speak in vague terms about accountability to the MSA's "membership, consumers and ultimately the community," and a "board that will be representative of its community and include a diversity of interests."

Regional government is accountable to the people through the municipal election process. Furthermore, regional council is constituted of member municipalities, somewhat on a proportional basis, and surely this is truly representative of the community in its broadest meaning.

When regional governments were established in the 1970s they were also given a mandate to serve the human and social needs of residents in the more densely urbanized areas of Ontario. They are accountable to the public through an open, democratic, electoral process and have established mechanisms for review and appeal of decision-makers' performance.

It does not make sense to us to create a new model of governance for essential public services when regional municipalities are prepared, qualified and legally entitled to provide such service. You have already heard this position from the Ontario Association of Municipalities in its continuing support for the role of municipalities as providers of human and social services.

**Mr Crichton:** There are a number of reasons why the region of York should have a strong leadership role.

First, the region has a long history of human service delivery. Since 1970 the region has, under the Regional Municipality of York Act, been responsible for the provision of a range of both mandatory and discretionary health and social services. In 1978, the regional municipality was also incorporated as the board of health. The region has a local focus and a proven ability to balance the needs of urban and rural residents.

Secondly, regional councillors are directly elected by the public. As we said earlier, regional councillors, by their electoral mandate, are directly accountable to the public. The existing electoral process ensures accountability to the public and, if there is a future commitment to reform of the electoral system in York region based on direct elections, then accountability to the public will only be enhanced.

Third, regional government has a sound administrative structure and experience with transfer payments from the province. The region already has an administrative infrastructure in place—for example, human resources, finance and legal services—so that the existing network of professional staff and support services could easily be applied to the provision of a fully integrated system of long-term care in the community.

In addition, the region administers numerous transfer payments from the province under many different acts,

having a diverse range of funding formulas and subsidy agreements. It already has extensive experience in managing transfer payments or service agreements for service mix, service level, quality, quantity and economy in such program areas as home care, hostels, child care and employment programs.

It is our contention that a regional management model would achieve the goal of one-stop shopping for community-based long-term care services by bringing together the existing expertise and organizational structures of the region of York with participating service providers in a mutually beneficial and ultimately more efficient, cost-effective and accountable way.

1450

We propose that the region take the lead role as the manager of the MSA, while existing community-based agencies retain their separate identity and program delivery systems. Regional resources would be directed towards coordinated administrative and case management functions, purchase-of-service activities and audit for quality control. In addition to the accountability requirements of the province, accountability to consumers and residents would be assumed as part of the existing relationship between the public and regional council.

**Dr Jaczek:** It is for these reasons we are suggesting in the strongest possible terms that the province remove the 20% limit on purchase of service by repealing section 13. We are also suggesting a change to subsection 11(3) to state the preferred designation of municipalities as approved multiservice agencies in areas where municipal interest has been expressed.

We do not believe that a multiservice agency as prescribed by Bill 173 will provide cost-effective or improved service to the many rural and urban residents of York region. Due to the haste with which this legislation has been drafted, there has been insufficient time to study its cost-effectiveness, its fundamental flaws or its impact for consumers. This bill should be delayed while additional study of other governance models and a complete review of the financial implications are undertaken.

**Mr King:** In closing, I would like to say we totally agree that there's no question that it's time the service to our residents should be reviewed. I think at the regional level—and I only speak for the region of York—we do have the administrative infrastructure. We also have a long history of serving our residents and meeting their needs. Again, I plead with you to make certain amendments to this bill which would provide the opportunity for us to further examine exactly how it should be done and hopefully it will be done in a way that will serve the residents of this province most effectively and efficiently. I thank you for hearing our position.

**Mrs Sullivan:** Thank you for your brief. We have heard from a number of other municipalities and I think one of the things that strikes us is that their impression is that people were, through the consultative process, looking for a mechanism to improve single access to a coordinated series of services. They were looking for a multiservice system, not a multiservice agency. In many communities such as your own—Waterloo was here earlier today—what we have found is that the municipal-

ities themselves were taken aback when this legislation came forward in this form.

I particularly appreciate your appeal for a delay while study of other governance models which would provide the flexibility to meet needs in each community are available, or at least an adjustment to the bill that would provide that flexibility, and a complete review of the financial implications are undertaken. We have been appalled to learn that there has been no feasibility study done, no cost-benefit analysis of this proposal and no pilot is anticipated.

I'm going to ask the parliamentary assistant once again if the government would undertake a pilot project with a review in order to conduct a complete review of the financial implications of this MSA model in comparison to a model such as that which is presented by the region of York where, in the past, a municipal system has worked and served the people in that community.

**Mr Wessinger:** No, we do not intend to proceed with a pilot project, but I might point out that this legislation is very flexible and permits a differing time frame for different areas for developing the proposals. I think there's a great deal of flexibility in the legislation as it is and we undoubtedly will see some multiservice agencies develop at an earlier stage in some areas than in others. Undoubtedly, those will be studied and looked at as examples for other areas.

**Mrs Sullivan:** There's not much flexibility when you have a four-year time line that's statutory.

**Mr King:** I think there are certain areas that we have outlined to you that need further examination. I think it would be folly to move into a process that has not been totally examined, whereby it may appear that it can be done better than it is at the present time. I think you should always look at all options. In my conversation yesterday with the chair of the district health council, whose responsibility it is to indicate the appropriate model for the delivery of this service—and we will be working closely with the district health council—they have not concluded yet what it should be or who it should be. All I stress again is that I think we cannot accept any additional cost for providing services and it would only appear in the best interests of all that we choose the best method.

**The Chair:** We have just a minute. I'm going to allow the other member from York to put one question.

**Mr O'Connor:** I appreciate you coming before us. I guess we have heard this type of brief presented to us before. We haven't heard a lot of people come and say, "Please create the MSA, not from the government but to another level of government." There hasn't been anyone saying, "Please shift it from one arm of government, because we don't agree with it, to another."

I guess another thing we hear is, what about the volunteer element? If government is running it, then you're not going to get volunteers out. If government is running it, then as to the fund-raising that does take place out there in the community today, how will that happen? I just wondered if you might want to comment on your ability to bring in volunteers that might be different than

if another level of government was to run it, or fund-raising. I know you're well aware of the process and the district health council isn't about to sanction one model over another, because they're going through a process still, and you'll be part of that.

**Mr King:** Let me respond to that this way and then I'm going to ask Mr Crichton to respond. I have not worked at the provincial level, but I certainly have at the local level for many, many years and it is very evident to me that it is much easier to get volunteers to work for local groups than it is any provincially organized body.

**Mr Crichton:** Our proposal would retain some of the positive features of the present system, many of the positive features of the present system. In fact, the hands-on delivery at the local level, the line people who go out and provide the home support services, the homemaker services, the nursing services, those kinds of services would be provided by existing agencies in the community that have a long association with the community, understand the community values, represent the diversity of the community and have established a volunteer base that has its roots in the establishment of the community, particularly a community like York that is young and growing. We think the model we propose retains that feature.

Make no mistake about it: We are advocating a brokerage model, but we're advocating a model that streamlines the current system, that brings more efficiency, brings more economy and brings more effectiveness to what you have now. You'll get more for your dollar than you will under a system that creates a new agency and that will increase the cost. Yes, you will save a few dollars on administrative costs by collapsing certain administrative costs under certain agencies, but in the long haul your costs will rise significantly and we think that money will only come out of the new funds allocated or existing funds, and therefore diminish the present level of service overall.

**The Chair:** I'm sorry that time is our enemy and I'm sure we could follow up on these and other questions quite profitably. May I again thank you for the presentation, the proposal and also the document which was passed at regional council.

1500

#### MULTICULTURAL ALLIANCE FOR SENIORS AND AGING

**The Chair:** I call on the representatives from the Multicultural Alliance for Seniors and Aging. Welcome to the committee. It is good to see you both again before the committee.

**Dr Dimitrios Oreopoulos:** I am Dr Oreopoulos. I am a busy kidney specialist at the Toronto Hospital, and Dr Joseph Wong is a busy family physician downtown. One common thing between both of us is that, in addition to being busy practising physicians, we are both very active in our corresponding communities.

I think for the last 10 to 15 years we both have witnessed some terrible stories involving members of our ethnic groups in trying to have access to the health care system. We can spend time to tell you various personal experiences but, instead of doing that, we both decided to

be founding members of the multicultural alliance for seniors. I would like to start by introducing a little bit of the association that we started in 1989 and then I'll let Dr Wong present.

The Multicultural Alliance for Seniors and Aging—MASA—was established in 1989 to represent the interests of the multicultural communities with respect to the needs of ethnic, older adults and their families.

The goals of MASA include: to provide mutual support to member organizations; to serve as a resource to multicultural communities in Ontario who wish to develop services for their seniors and to mainstream seniors' agencies who wish to provide services to multicultural communities; and to provide advice to government and planning bodies regarding the needs of multicultural communities for long-term care facilities and community-based services.

MASA has more than 40 member organizations in Metropolitan Toronto and Hamilton, representing over 25 different ethnocultural communities. I would like to draw your attention to this little brochure with the names of the organizations that are represented in MASA. Some of these have well-established services, some are in the process of developing services, while a number of communities are in the planning process. In total, I think we represent more than 40% of the ethnocultural groups in our city. It is our view that, through mutual support and collaboration, we will better serve the needs of our respective communities and the residents of Ontario.

**Dr Joseph Wong:** On behalf of the members of MASA, we wish to express our support for the ongoing efforts of all members of the Legislature to develop a system of long-term care which will effectively meet the needs of Ontario's seniors and disabled.

We believe MSAs are an essential component in reforming the delivery system of long-term care services. At the same time, our purpose in addressing you today is to place before you certain recommendations, which we believe will strengthen the ability of these agencies to serve the needs of ethnic seniors and their families.

Our members strongly support the third right of the proposed bill of rights for persons receiving community services, which states: "A person receiving community services has the right to be treated in a manner that recognizes his or her individuality and that respects cultural, ethnic, spiritual, linguistic and regional differences."

However, in order to ensure that this right is protected, it is essential that services be planned and organized in such a way as to empower ethnic seniors through their various communities.

In her letter to Metropolitan Toronto District Health Council, the Minister of Health emphasized that the planning process for MSA implementation must take into account the needs of different ethnocultural communities. She further indicated that some planning consortia will identify themselves as leads for various ethnocultural communities. We believe this makes good sense, because it will allow for the concentration of resources in order to maximize quality and efficiency. We further believe that Bill 173 should reflect this commitment.

MASA therefore recommends the addition of the following subsection to paragraph 11: "The minister may designate a multiservice agency as a lead agency for an ethnocultural community."

This will ensure consumers' choice with regard to appropriate linguistic and cultural services anywhere within a planning district. This will also maximize the efficiency and cost-effectiveness of available resources. However, the establishment of lead MSAs for different ethnocultural communities should not reduce the effort and commitment of other MSAs in providing appropriate cultural services to their constituents within their own catchment areas.

**Dr Oreopoulos:** MASA members endorse the requirements for board composition of MSAs described in Bill 173. However, we believe that the legislation should outline a process for ensuring that ethnocultural communities are appropriately represented. Specifically, MSAs should be required to solicit nominations from ethnic community organizations in their geographic areas. In addition, there should be a formal appeals process for groups which feel that their communities have not been adequately represented.

Bill 173 envisions a system in which ethnic seniors will receive services which are culturally, linguistically and spiritually appropriate. However, it establishes no framework for ensuring that such services would actually be delivered. MASA therefore recommends that subsection 20(1), which deals with service plans, be amended by adding clause (d) as follows: "for each person who is determined to be eligible, develop a plan of service which takes account of the person's preferences based on ethnic, spiritual, linguistic, familial and cultural factors." This language is consistent with the language of Bill 101, dealing with care provided in long-term care facilities.

It is the view of MASA members that the legislation should also require MSAs to develop training programs for their employees and volunteers in order to sensitize them to the special needs of ethnic seniors. We therefore recommend the addition of the following to section 20: "An approved agency shall develop training programs to sensitize their staff and volunteers to the ethnic, spiritual, linguistic, familial and cultural needs of persons receiving services."

Finally, MASA members welcome the proposed amendment to the Ministry of Health Act concerning the selection of persons to be appointed to the district health councils. We endorse the need to ensure that the membership of these councils reflects the diversity of the communities for which they are planning. However, based on our experience with planning for MSAs, both in Metropolitan Toronto and other districts in the province, we believe that the provisions of the legislation are inadequate. In many cases, we and our colleagues throughout the province found extreme insensitivity to the needs of ethnocultural communities and a profound ignorance about the problems faced by ethnic seniors and their families in assessing services.

It is essential, in our view, that district health councils be required to establish multicultural service committees with specific responsibility for planning health and social

services for the members of ethnocultural communities. Thank you for the opportunity to address the standing committee on these matters.

**1510**

**Mr Tilson:** Sir, I was interested specifically in your comments about the number of your member organizations. I think you mentioned there are 40 in Metropolitan Toronto and Hamilton. The major concern of many private sector groups that have come forward to the committee appears to be the impact of the 80-20 rule; in other words, that MSAs are only allowed to purchase 20% of the services from outside the MSA. They feel that the private groups, the small groups, the service groups such as VON and Saint Elizabeth Visiting Nurses, will simply disappear.

I guess my question is whether you've addressed your concerns with that. I'm looking at your existing services. I appreciate the amendments that you're recommending to enable the people in the various communities that you represent to have these services. Does MASA—the 40-odd member organizations, and there may be others—fear that these groups, these existing organizations, will disappear as a result of this legislation?

**Dr Oreopoulos:** I don't think we should be the right persons to address this, Mr Tilson, but the concern is that we already have problems with these organizations. If you call home care and you tell them that there is a person who doesn't speak a word of English, they will have difficulty sending a person. What we're in front of you here to say is that, in the development of the MSAs, we can make sure that we eliminate these problems that we already have so many of.

**Mr Tilson:** I understand what you're saying. I guess the problem with the legislation is that we're supposedly all the same; the difficulty is that we're quite obviously not all the same. There are many different cultures all over the province that have different individual problems and need individual attention. I think that's the concern, that we've got this Big Brother attitude that in effect is going to cause more problems. I think you would agree with that.

My question is directly to the existing organizations. If you get the funding, you're okay. But obviously on an 80-20 formula, those groups aren't going to get the funding; they're gone.

**Dr Wong:** We did address this problem, this particular issue and concern, in MASA meetings. As a matter of fact, the overwhelming majority of the members of MASA are not very satisfied at all with the present system. The present system does not pay any attention to differences in culture, to differences in language.

I'm using my practice as an example, and I'm quite sure it generalizes to people from other ethnocultural communities. Seniors of Chinese origin are not able to receive services in their language, in their culture, so every time the seniors came in and complained that although there are some visiting personnel, health or social services going to their home, nevertheless they were not receiving the appropriate help. It is very difficult for us to request VON, home care or other organiza-

ations to send somebody there who knows the language and the culture.

We can't understand why this cannot be done, because there is no lack of people, professionals or other workers, of Chinese origin who can speak both languages, English and Chinese, who could serve these seniors as well and at the same cost as other people. But this problem has long been ignored.

**Mr Jim Wilson:** But does that mean we just get rid of the VON and the Red Cross? That's what this bill does, make no mistake about it. Who says the MSA, even if you get all this representation—because it's a government-run thing basically—is going to correct those historic problems?

**Dr Wong:** I'm not quite sure MSAs are government-run things. It is government-funded, but it would be composed of agencies from a planning consortium, from a planning district, a planning region, which come together. For example, in the region where I am coming from, from northwest Scarborough, about 10 different agencies are coming together to plan MSAs to serve northwest Scarborough. Yee Hong Community Wellness Foundation, St Paul's L'Amoreaux, VON, home care, Red Cross—including Red Cross—and a number of other smaller organizations which serve the district will come together to plan the MSA serving that particular area. So we do have input from the existing organizations as well.

If the MSA is an idea whose time has come, if it means abolishing some established organizations in order to build a better system, I would say, so be it, because the present system cannot persist. I could bring out so many seniors in my own practice, and I'm quite sure Dr Oreopoulos and other people would be able to tell you that the linguistic and the cultural aspects of care, which are very important, have long been ignored by the system, and I think we have to do something drastic to change it.

CANADIAN MENTAL HEALTH ASSOCIATION,  
ONTARIO DIVISION

**The Chair:** I call on the representatives from the Canadian Mental Health Association. Good afternoon.

**Ms Carol Roup:** We from the Canadian Mental Health Association very much appreciate this opportunity. My name is Carol Roup. I'm the senior director of policy research and branch services with the provincial organization of CMHA. Ruth Stoddart is our executive officer, and Lisa McDonald is a community mental health consultant with our organization; one of her special areas is long-term care. We are members of staff of the CMHA, and in that capacity we're representing the views of our board.

Although this presentation and our submission were, by necessity, done in quite a rush, I do want to say that we did extensive consultation within our organization, and it's based on this consultation that our board arrived at its views and at the submission that you have before you.

For the purposes of the record, the CMHA, Ontario division, is an incorporated, registered, non-profit charitable organization which was chartered in 1952. Over 4,000 volunteers are active in direct board, committee and

direct service provision in a network of 36 branches located in communities across the province. Ontario division and branch services and programs receive funding from government grants, local United Way branches and supplementary fund-raising activities.

The Canadian Mental Health Association is primarily concerned with the impact of reform of the long-term care system on people with serious mental health problems and their family members. So our response to the Long-Term Care Act highlights issues of particular concern for these individuals and their families; however, some general concerns have been raised.

We realize that our time is really short. We have no intention of reviewing our submission word-for-word. I'm going to ask Ruth Stoddart to deal directly with the importance that we place on its impact on people with serious mental illness, and Lisa McDonald will deal specifically with issues of concern around multiservice agencies. However, I really would urge you to read it because we do make some points about district health councils and the role of volunteers, which we also think is really important, but we're going to deal with our two major issues.

1520

**Ms Ruth Stoddart:** Our first concern has been stated as primarily with the needs of people with serious mental illnesses. We're aware that clause 1(c) of the legislation implies that the receipt of community-based long-term care services will be based on need. We have noticed, however, that the compendium that was put out as a companion piece to the legislation seems to emphasize throughout that community-based long-term care and support services are to be provided to the elderly and people with physical disabilities. There is no direct mention anywhere in this companion piece to the legislation about people with mental illnesses or mental health problems. We're very concerned about this because, as is understandable, we feel that a lot of people will read the compendium rather than attempt to read the entire piece of legislation, and it may have a direct effect on service delivery.

There are several groups in particular that we're concerned about, the first being elderly persons with mental illnesses who require psychogeriatric and other long-term care and support services; that is, those people who are already in the long-term care system but also require some sort of mental health services. In addition to this, there are also the elderly who had some form of mental illness prior to becoming 65 years old or becoming a person eligible for services for the elderly.

The second group of people that we are concerned about are individuals who have both physical and mental disabilities. These people may already be in the long-term care system but certainly also require care for their mental disabilities.

Third, there are many people with serious mental health problems who require community services and supports in order to live in the community. These people often require long-term care services and supports although they may not be elderly or have physical disabilities.

Finally, the families of people with mental illnesses often are the care providers for these people and certainly do need services and supports. The Canadian Mental Health Association, Ontario division, would like to recommend that all individuals who require long-term care and support services in order to remain in the community should be eligible for those services. We would urge that the reason that supports are given to these people should be considered only in developing the service plan under the legislation, not with respect to whether or not services should be provided to people.

Finally, with respect to people with mental health problems, paragraph 56(1)16 of the legislation allows for regulations to be developed to determine eligibility criteria for people who will receive long-term care and support services. We would urge that these regulations, when they are developed, not exclude anyone who requires long-term care services.

The second thing I'd like to talk about is the coordination of the mental health reform initiative of the Ministry of Health and the long-term care reform. Coordination of these two reform initiatives is necessary because, as I've stated, there's a strong interrelationship between physical and mental illnesses, especially among the elderly, and there is a need for both systems to provide appropriate and effective services in a coordinated manner.

We would recommend that the definition of "professional services" in subsection 2(7) of the act include psychogeriatric services to ensure that there is a coordination between the two systems.

Additionally, we would urge that MSA staff be trained in doing psychiatric or psychological assessments as well as knowing about mental health services which are available and also the reverse, that people in mental health service agencies certainly be trained to know about long-term care services and supports.

We feel that age or disability should not determine which system, that is the long-term care system or the mental health system, should provide services for people in need. Access to appropriate services should be based solely on need, with the least possible disruption to the person receiving the services.

Finally, we would also like to talk about the coordination of the long-term care reform with services currently being offered by other ministries in the province of Ontario. The CMHA, Ontario division, is concerned that the original long-term care legislation came from three different ministries in collaboration. The most recent version of the legislation is solely the province and the Ministry of Health. Several problems could arise with this. For example, the Ministry of Health bases its services on district health council boundaries. Unfortunately, a lot of long-term care services are provided through the Ministry of Community and Social Services as well as other ministries, such as Housing, which don't have the same regional boundaries within the province. We would like to see coordination and cooperation among all the ministries in providing services, primarily because the most important thing is providing services to people in need.

**Ms Lisa McDonald:** I'm going to talk specifically about multiservice agencies. CMHC, Ontario division, supports the concept of simplifying access to the complex system of available long-term care and support services. Within the Long-Term Care Act, the proposed solution to simplifying access to the system is the establishment of multiservice agencies.

The primary concern of CMHA, Ontario division, is improving access to long-term care services for those who require them. We'd like to point out, however, that the establishment of MSAs may or may not be the best way to achieve this, and it's certainly not the only approach. It's not been demonstrated, for example, that structural and governance reorganization necessarily lead to better service provision. There must be recognition that there's no guarantee that MSAs will in fact improve the current system. The approach being taken in the mental health system is to improve access to services through the enhancement of case management services, which doesn't necessarily involve a structural reorganization of service agencies.

Given the key role to be played by MSAs, however, CMHA is concerned about specific areas of the legislation that deal with accountability, approval of MSAs and board composition.

First, with respect to accountability, Ontario division recommends that the following areas be reviewed.

The minister retains sole decision-making power with respect to the approval of an agency to provide a community service, and under section 9 "may impose terms and conditions" of approval. These terms and conditions require further clarification within Bill 173, and the circumstances under which they can be changed or removed should also be described.

Section 56, paragraphs 34 to 36, also specifies that regulations may be made governing the membership, selection of the board, management and operation of approved agencies. Also included are takeover powers by the minister, which include the power to remove MSA directors and appoint others and the power to take control of, operate and manage MSAs. We're concerned that community ownership and accountability for service providing agencies to their local communities could be reduced by these regulation-making powers. Of primary importance to CMHA, Ontario division, is the assurance that MSAs are governed, managed and operated in such a way that identifying and responding to the specific needs of local communities are given very high priority. This ability to be sensitive and responsive to local needs must not be hindered by regulations developed in the future.

Also, according to the legislation, service providers will be required to provide reports and information to the minister. This seems to be more clearly explained in the legislation: For example, what kind of information will be required and for what purposes, and how will this information be collected when services are contracted out?

Regarding approval of MSAs, subsection 11(3) of the legislation states that a municipality or a board of health may be designated as an MSA provided that the suitability of all other approved agencies in the geographic area has first been considered. With many of its 36 branches

across the province located in rural and northern communities, CMHA, Ontario division, is very aware that many areas of the province have very few agencies that provide mental health and other support services. We're concerned that it is within these rural and northern municipalities that a municipality or a board of health will become the multiservice agency simply due to a lack of options.

When a municipality or board of health is designated a multiservice agency, it must provide the same services and adhere to the same requirements of other MSAs. For example, presently it's unclear how a municipality or a board of health would meet board composition requirements. If municipalities and boards of health are not bound by the same rules and procedures outlined for MSAs, we're concerned that access to a range of services will not be consistently ensured across the province.

With respect to board composition, we'd also like to make some recommendations. One of the factors to be considered in determining the designation of an approved agency as an MSA is whether its board of directors "reflects the diversity of the persons to be served by the agency in terms of gender, age, disability, place of residence...and cultural, ethnic, linguistic and spiritual factors."

CHMA, Ontario division, would like to see this section of the legislation strengthened so that it's not only one of the factors considered but a requirement. This is especially important if ethnorracial communities are to be appropriately served by MSAs. Family and other care givers should also be specifically included on the board.

1530

I'd like to make some comments now on the provision of services by MSAs.

The four kinds of community services that will be provided by MSAs include community support, home-making, personal support and professional services. Limitations on purchasing services from independent service providers rather than providing service directly are placed at 20% of the approved budget in each of the four categories. In order to allow for MSAs to be phased in, the legislation allows for MSAs to be exempted for up to four years from the requirement to provide access to the mandatory services in the four areas and from the 20% limit on contracting out services.

Safeguards need to be built in to ensure that MSAs are allowed exemptions only if consumers and care givers have other options for accessing services or supports that they need. Although we recognize the need for a transitional period for the development of MSAs, the ability to ensure provision of long-term care services and continuity of these services during this time is critical.

We're also concerned that MSAs will not be required to limit the purchase of services from individual providers to 20%. This would allow for a situation in which an MSA provides only information and referral, and purchases all other services and supports from individuals. This would certainly not be consistent with the mandate of MSAs to provide one-stop access to the full range of community services.

Again, this may be more likely to happen in the rural and northern communities which have a shortage of community services. It's not clear how the mandatory community services outlined in the legislation will be provided in these areas. There's also a need to make allowances for the transportation requirements of individuals living in rural communities. While services and supports may exist to serve consumers and care givers, access to them is denied if distance, a lack of suitable transportation or the resources to pay for it are not considered.

This is a particular concern, given that the act specifies that some fees will be charged for services that incorporate transportation expenses. There is the potential to create a system in which those for whom transportation is not an issue, due to proximity to services or the ability to pay, receive one kind of service and those who live in rural areas and can't afford transportation receive only those services that are provided without cost. That's assuming that there are free services in the area.

In addition to the services an MSA "must" provide, the minister "may" authorize provision of additional services. We recommend that decisions to provide such services should be driven by demonstrated community need. As well, the focus in developing services within MSAs must remain on serving those people whom long-term care and support services are intended to serve.

With severe cutbacks in the health care system, we're concerned that there will be insufficient resources to implement long-term care reform in the way that it has been envisioned. This is particularly an issue within rural areas. This concern is heightened by reductions in hospital beds in both the general and psychiatric hospitals. The Long-Term Care Act must guarantee access to services that are currently provided under the Canada Health Act, for example, home care, without the threat of user fees being introduced.

Subsection 25(2) of the legislation should therefore be changed to rule out the possibility of the development of regulations allowing charges to be applied to certain services. With respect to assessing consumer need, the legislation also reserves the right to develop regulations to govern eligibility, amount of service provided, ability to pay and assessment. The criteria to be used to establish these regulations need to be included within the Long-Term Care Act.

The Long-Term Care Act has wide-ranging implications for those who require community-based long-term care and supports. This includes a great number of people who have mental health problems. Some individuals require long-term care and supports because of the serious and chronic nature of their psychiatric disability alone, whereas for others with mental health problems, the need for these supports is also related to the fact that they are elderly or that they have a physical disability or a physical health problem.

We have made a number of recommendations in our submission with a view to ensuring that those with mental health problems are appropriately served. In addition, we have commented on the proposed legislation in terms of how services are to be provided. With respect

to this issue, CMHA, Ontario division, emphasizes the need for all agencies and structures that will be responsible for implementing long-term care reform to be governed by boards that are reflective of the community that requires long-term care and supports. This accountability to the local community must also be preserved in the development of MSAs and the designation of approved agencies.

**The Chair:** Let me interrupt you for a second, because I know you're about to say, "In conclusion." You've done extremely well with your time and I just wanted to say there is time if you want to just highlight, because I noticed you had to leave out three sections. If there are a couple things you wanted to say about those sections, there is time for that and also for a question.

**Ms McDonald:** Perhaps we'll just take a part out of where we talk about district health councils.

The amendment to the Ministry of Health Act will allow the government, through guidelines and regulations, to ensure that long-term care committees of DHCs are reflective of the communities they serve. CMHA, Ontario division, would urge that this be a requirement as well and that this be included within the legislation itself. Our organization recommends that requirements governing the composition of DHCs and their long-term care committees be similar to those recommended for governing the composition of MSA boards, that is, that they reflect "the diversity of the persons to be served by the agency in terms of gender, age, disability, place of residence... ethnic, linguistic and spiritual factors," and that additionally, family members and care givers be included.

We also point out that in order to fulfil the considerable mandate given to district health councils within the long-term care legislation, DHCs currently lack adequate resources to meet the current responsibilities they have, and that includes the implementation of mental health reform and all other health planning. CMHA, Ontario division, believes that inadequately funding DHCs will very likely lead to inappropriate and/or inconsistent implementation of long-term care reform across the province.

Do we still have time for another highlight from another section?

**The Chair:** Probably one quick one and then, "In conclusion." I know you've taken a lot of time to prepare this and you've hit a lot of the key issues that we've been addressing. I just thought this way you can get some of those comments on the public record.

**Ms McDonald:** I think we'll talk a little bit about our concerns around voluntary agencies. One of the concerns of our organization is that funding is currently provided by agencies such as the United Way as well as donations from individuals, and that these won't necessarily continue to be provided to the MSA. It must be recognized that many agencies currently providing long-term care and support services rely on these kinds of contributions to maintain their service, and every effort must be taken to ensure that these very valuable resources are not lost to the system.

In conclusion then, CMHA, Ontario division, would

like to emphasize that both the mental health and the long-term care systems have a responsibility to provide services to those with mental health problems. What must not happen is that those with mental health problems experience difficulty in receiving service within the mental health system because they're elderly, and/or they're excluded from services within the long-term care system because they have a psychiatric disability.

The need for long-term care and support services should be the only criterion which determines eligibility for service covered by the Long-Term Care Act. Extreme caution must be exercised in further defining the eligibility for services to be provided through MSAs to ensure that exclusionary criteria are not developed. A great deal of care must also be taken to ensure that individuals providing mental health services are adequately knowledgeable about long-term care issues, and similarly that those providing long-term care and supports are knowledgeable about mental health. Placing a high importance on consumer choice and the ability to provide services in a flexible way are essential considerations in the development of this legislation if those with mental health problems are to be appropriately served.

**The Chair:** Thank you very much for that presentation. I can assure you that members have lots of material to read, but we do read it.

**Mr Martin:** Thank you very much. You've certainly put a lot in front of us in a short period of time, a lot of good material, I think valuable recommendations, some of unique feature to your own concern, the mental health field, and some certainly that reflect concerns that others have brought forward.

Overall, I think I heard you saying that you supported an initiative that would deliver services of a long-term care quality to communities that give a high degree of local control over what happens, and I heard you saying that it was important that there be equity of access across the province, that no matter what little hamlet you get into, people should have services to deal with their particular need, and you talked a bit about the need to make sure we weren't shortchanging the system either in terms of money, that there were resources needed if we were going to do this. That's what this legislation is built on, all of that plus the fact that we're right now in the middle of spending a fair chunk of money, about \$450 million, in trying to enhance the services for people in need of long-term care in the province.

1540

I wanted to zero in on something that was raised this morning by a group of psychiatrists and medical people in the field out there who have a concern about this as well. It's the issue of dealing with the reform of mental health care and the reform of long-term care at the same time, and do they fit together or do they not fit together? They're both big, big efforts. It took us 10 years to get to a point where we now have a piece of legislation in front of the government of Ontario that I don't think you want us to stop. We need to move forward with that. At the same time, we're reviewing the mental health area, which is a big piece as well.

My sense, from working with this over the last few

weeks and hearing from people and trying to get my own head around it, is that this piece of legislation will put us in a position to be able to take in any reform to the Mental Health Act. I see consistencies. I see that we can build on this. I'm wondering if that is a feeling you share as well and if there are any thoughts there that might—

**Ms Roup:** I think that's the hope, and separately they both have enormous potential, and as so often happens when you read a piece of legislation or government policy, it has all that potential. I guess in highlighting some of our concerns, it certainly wasn't our intention to be negative about either. We've strongly supported reform to the mental health system and we've supported reform to the long-term care system. I think our concern is that they should be integrated and it's a serious concern.

In mental health reform, our organization continues to emphasize a continuum of services, both institutional and community, in which any given individuals could fluidly move in and out of different kinds of services they might need at different times in their lives or in different periods of their illness. So we'd want those two systems to interact in that way. We wouldn't want to see someone who happens to be in a psychiatric hospital now reach 65 but somehow get stuck there because that's the system he's stuck in. If these two systems are to jointly set up a continuum of services, it should be easy for people to flow from one to the other. They shouldn't be seen as blocks, but they should be part of an integrated system. So I think all the potential is there.

**Mr Martin:** If I might have one little supplementary, I hope—

**The Chair:** One little supplementary.

**Mr Martin:** Are you encouraging your people on the ground out there in the communities—I know we have a chapter in Sault Ste Marie—to be part of the local planning process for this?

**Ms Roup:** Very much so.

**Mr Martin:** You think that's really important?

**Ms Roup:** Very much so, but I think the point about district health councils and their capacity to conduct local consultation, both on mental health reform and long-term care, is that it's huge and we're not sure if it's a doable thing. Meaningful consultation from a district health council, which in some cases may have two or three staff and volunteers, is a huge mandate. But certainly, from our branches' perspective, we're encouraging them to assist DHCs to do that and to be involved in the consultation.

**Mr Martin:** I believe there are designated staff for this given to district health councils to carry this thing out.

#### HOME CARE PROGRAM FOR METROPOLITAN TORONTO

**The Chair:** I call upon the representatives from the Home Care Program for Metropolitan Toronto, if you would come forward.

**Mr Jim Wilson:** On a point of information for the committee: Upon agreement with the Liberal caucus members here, if it's all right with you, Mr Chair, if I can

have the next question, the Liberal Party then will take the optometrists. Unfortunately, I have to leave after this presentation.

**The Chair:** I'm sure it will be full of wit, pith and substance.

**Ms Marian Walsh:** My name is Marian Walsh. I'm the president and chief executive officer of the Home Care Program for Metropolitan Toronto.

**Dr Phil Daniels:** My name is Phil Daniels. I serve as the chair of the board of directors. First of all, thank you to the committee for the opportunity of coming to present to you today. You have a brief and, as you said before, you have lots of things to read. We'll try to hit some of the highlights and hopefully save some time for some interaction.

First of all, just briefly who we are. This is our 30th anniversary—

**The Chair:** Happy birthday.

**Dr Daniels:** It's a big year. Thirty years ago the home care program was strictly for those with acute care needs of a short-term nature. Over those years we've evolved into a comprehensive home care-home support organization now serving 14,500 residents on any given day and 42,000 over a period of a year.

We serve all age groups from infants to elderly, from those with physical care needs to those with mental health care needs, as I think might relate to the previous presenters, and certainly from those with complex, acute, chronic, rehabilitative and palliative needs to those with long-term care needs.

Our service delivery covers nursing, physiotherapy, speech therapy and all the other myriad of services that you see listed. The home care program also provides assessment and case management and case coordination services for all individuals referred for its care. The availability of this important part of our service delivery ensures a current, one-stop access and coordination system for those who require in-home services in the Metro area.

The program organizes its service delivery, offering a variety of programs that have been designed to meet the needs of a diverse population. The programs include acute care, chronic care, palliative care. We also have a school program for children, acquired brain injury program, complex care, a quick response program, which I think has worked rather well, and the integrated homemaker program, the IHP.

In carrying out our work, one of the areas of sensitivity is cultural sensitivity, and that's noted through contract arrangements with a wide range of service providers, which gives it access to an ethnically diverse workforce and also through translation arrangements that are provided within the home care program staff as well as through a contract with Access Alliance.

Beyond our commitment to efficient, effective in-home services delivery in Metro, the home care program's board and staff are committed to working in partnership with the community, the government and other providers of health and social services in Metro.

The commitment takes us beyond considering just our

own role and our own future in terms of the evolution of long-term care as proposed in this legislation, and in fact we are talking about concerns and hopefully places that this act can be strengthened, not from home care's point of view but from the health care point of view in terms of all the residents certainly of Metro but all of the residents of Ontario. It's in this broader context that we pass along, hopefully, some thoughts that might be useful to you.

**1550**

In terms of general observations there are three areas, and I'll comment on each of them.

The bill, as we read it, and we've highlighted this in our presentation, does not contain any vision for long-term care that specifies what long-term care is, who it is intended to serve, who is entitled to receive long-term care and how the various components of the long-term care system are intended to work together to ensure access to a coordinated continuum of care.

Second, we have some concern with what we perceive to be the deinsuring of home care services through this bill. At the present time home care regulations under the Health Insurance Act provide automatic entitlement to health care services to any insured resident of Ontario. By removing these provisions from the current legislation and not clearly stating entitlement and eligibility criteria in this legislation, it would appear as though it is the government's intention to deinsure home care. While such actions may be appropriate in terms of the long-term care component of the system, which historically has been available to individuals on a subsidized versus universal basis, we have some considerable concerns about the implications of deinsuring of home care for acute, chronic, rehabilitative and palliative care.

The third area where we have some concern is how prescriptive the act is as it is written; that is, that it is prescriptive to the point that it becomes operational in its direction. I think the legislation runs the danger of putting community boards, voluntary sector, in a position of wondering what they are they for. If they are there for local stewardship, then they must have some flexibility in terms of carrying out those mandates.

If indeed the legislation is to tell them point by point exactly what to do, then again, volunteers, whether they be volunteering their time in terms of services or volunteering their time in terms of leadership on boards and committees, will begin to question their real role in the whole system, and I think that would be a loss for the system.

Those are some general concerns, and I'm going to hand it over to Marian to look at some specific highlights of concerns and will finish off with some specific recommendations we would suggest.

**Ms Walsh:** While, as Dr Daniels has already indicated, the program does support the purposes of the Long-Term Care Act as set out in this bill, we have some concerns that the specific provisions of the act do not ensure, and in fact in certain instances actually work against, the stated purposes of the bill.

Our specific concerns about the provisions of the act

in this regard include, first of all, the multiservice agency concept. It seemed to us, in examining the bill, that the cornerstone of the government's reformed long-term care system, and therefore the key component of the bill, was the establishment of the multiservice agency.

These agencies, according to the bill, will be required to provide access to and coordination of the long-term care services under their jurisdiction, but will also, under this bill, be required to be the primary direct service provider of those services by virtue of subsection 13(2) of the act.

This section limits the purchase of service in all categories by MSAs to 20%. Now essentially what this means in the Metro Toronto area, as one example, is that the current home care system, and thus the home care program for Metropolitan Toronto, may be divested to the 15 to 22 MSAs that are currently being contemplated for implementation in this area. At the same time, it may also mean the merger and/or the centralization of the approximately 250 community support agencies that have grown out of the voluntary sector in this area to meet the specific needs of local populations in their communities.

The implications of this change for the community support services system of the Metro area, and more importantly for the people who live here, and for the objectives of long-term care reform are, in our view, quite substantial, and we'd like to try to point out to you how they are substantial, first of all with respect to single access.

In terms of single access, the home care system currently provides a one-stop access for all insured home care services, which includes all services contemplated to be delivered by the MSAs in Metro Toronto, with the exception of community support services. That single point of access is currently available to all clients across the full spectrum of care needs, from acute care through to chronic, rehabilitative, palliative, school care and so on, on through to long-term care but not just limited to long-term care.

While we do acknowledge that improvements need to be made to better coordinate access to all services, including community support services, and to provide that access at more local levels and closer to the people that we serve, we simply don't understand how turning a single access point for what is essentially now 75% of the future care delivery system into 15 to 22 access points improves the system.

Another objective of long-term care reform is to ensure that individuals have access to a wider range, not a lesser range, of services in the community. We acknowledge that access to the approximately 250 community support agencies in the Metro area needs to be better coordinated, both among those agencies and between those agencies, in what is the current home care system.

However, what is contemplated in this legislation is not just the coordination but in fact the centralization and therefore the elimination of the voluntary sector through the integration of those agencies and their services, at least in the case of Toronto, into the 15 to 22 MSAs contemplated for this area. While this may improve the entry part of access by streamlining entry from 250 to 15

to 22 locations, it seems to us that what is sacrificed in the process is the range and diversity of services that these organizations provide.

Community support agencies in Metro Toronto have grown out of the need to provide services of a specialized nature to meet the needs of specific populations, whether these needs arise out of ethnic origin or out of special care need. Furthermore, these organizations carry out their work in a much more flexible manner than has been or is possible in a more formal, publicly funded environment. Thus, instead of broadening the range of services that people have access to, this legislation will result in our view in a considerable shrinking of the range and diversity of services available to the population that requires long-term care.

Beyond the home care and community support agencies that will be directly affected by this legislation if MSAs come into effect in Toronto in the way in which they're contemplated, there are also all of the other service provider organizations, both not-for-profit as well as proprietary, that have and continue to contribute a richness and diversity to the service delivery system available to the people of Ontario. In Metro Toronto the home care program currently purchases services from some 50 organizations which deliver everything from its nursing on through to its transportation services.

Having such a wide range of service delivery organizations available to the home care system has meant, first of all, that we have a wide range of special skills to draw on, as agencies have developed areas of special expertise.

Secondly, we have now developed the capacity, and only very recently given the economies of scale that we now have in Metro Toronto, to serve almost the full range of ethnic communities and groups that exist in Metro in an ethnoculturally sensitive manner.

The home care program and therefore the government through us as its agents have contributed to improved access to these now highly developed and specialized services for all of the people who require them in Metro Toronto, whether they are serviced through the publicly funded home care program or through private means. We would like to point out that estimates in our own field would indicate that essentially about 50% of the people who actually receive home care services in the Metro area on a daily basis are receiving those services through the publicly funded system.

We are also concerned that the funding that has been provided to these organizations through the home care program has enabled many of these organizations to develop other programs and services that are not part of home care but are nevertheless now available to the community as a result of home care.

Once MSAs come into effect, we have some concern about what we know will be the tension on the one hand between a system with a limited and fixed amount of resources and on the other hand a growing number of individuals, particularly elderly and disabled, who will be in need of care at higher and more complex levels.

Unfortunately, we would predict that the net effect of these tensions will inevitably be that if all services are

put into the one basket, community support services that are now provided largely to the well elderly for preventive purposes will essentially be eliminated or traded off in order to ensure adequate provision of higher levels of service to those who will shortly need it.

We also believe that the mandatory move away from purchased service to direct service delivery has significant implications for consumer choice. With some 250 community support agencies available in the Metro area, plus the 50 agencies that the Metro Toronto home care program contracts with, the availability of choice for people in terms of who delivers their service is quite significant, whether you receive service from the public system or through some other third party or private means.

The elimination of these agencies either directly through centralizing them into MSAs or indirectly through the elimination of public funding for the purchase of these services and the threat that that would pose to the viability of these organizations will inevitably result in reduced choice for consumers and clients of in-home services.

#### 1600

What may emerge as a result of this restriction on the purchase of service is the development of a two-tier, in-home services system where those who can afford choice will purchase it and those who cannot will have no choice but to remain with the publicly funded provider of service. This, we believe, would be a tragedy for a community services system whose basic values revolve around consumer choice and where a major objective is the establishment of a more versus less equitable system.

Finally, we believe that the MSA concept has the potential to add significantly to the operating and delivery costs for in-home, long-term care services. As we see it, MSAs as they are currently conceptualized will become the primary providers of all in-home services and therefore will monopolize community service delivery. This will inevitably result in a significant reduction in the number of service provider agencies operating in Ontario and in Toronto and thus eliminate the current potential for competitiveness in the marketplace and the efficiencies that are achieved in such a competitive environment.

In the current system the voluntary sector contributes substantially towards the cost of service provision in the community in a number of ways: first of all, through the provision of direct services such as Meals on Wheels, transportation, friendly visitor and so on; secondly, through fund-raising and financial as well as in-kind operational support provided by sponsoring agencies at the local level.

Once these organizations are eliminated and folded into the publicly funded MSA system and have lost their community roots and identity, the people who volunteered their services to these organizations will no doubt cease to make those contributions. We would invite you, if you have any misgivings about that, to look at what happened in Quebec when the government introduced the CLSC system, which is not unlike what is being proposed here in terms of the MSA system in relation to its effect

on the voluntary sector.

We also predict that the costs of centralizing, in the case of Toronto at least, the 250 community support agencies into a larger, more bureaucratic public system will far outweigh the combined operating and overhead costs of those agencies at the present time. Many community support agencies operate in non-union environments, in small, informal office premises that are frequently donated by churches or other sponsoring local organizations. Their overhead costs are generally at fairly minimal levels and as a consequence their operating and service delivery costs are relatively low.

The home care program achieves economies and efficiencies on the other hand through a centralized approach to administration and to the delivery of specialized services. The added cost of decentralizing the entire administration and specialized service delivery components of the home care program and the cost of replicating that in 15 to 20 different locations in Metro Toronto would we suggest be considerable.

**Dr Daniels:** I want to come back to a point that we heartily support: the aims and principles of long-term care reform. I want to make that quite clear. It's from that spirit that we offer some recommendations and suggestions in terms of the proposed legislation in ways that it might be strengthened:

—That a section be added to this bill that defines long-term care and the population to be served by the long-term care system.

—That a section be added to the bill which sets out the relationship between in-home and institutional long-term care services and between long-term care services and the rest of the health care system.

—That a section be added to the bill which prescribes the eligibility for in-home services and ensures that such services are provided to individuals on an insured basis, at least for acute, chronic, rehabilitative, palliative and other hospital or otherwise insured replacement services.

—That section 13 of the bill be amended to eliminate the restriction on purchase service and to redefine the mandate of MSAs as being to provide service coordination with the possibility of a variety of service delivery models to be determined at the local level.

—Finally, that section 56 of the bill be amended to eliminate the level of prescriptiveness of the bill to allow for the kind of flexibility and community-board management of the system that is required if the objectives of long-term care reform and the purposes of this bill are to be achieved.

With that, we thank you for your time and hope we've been of some service to you.

**The Chair:** Thank you very much. I note as well for the record that this was a very full brief and there are other sections within it that you weren't able to read into the record, but we will certainly look at those.

**Mr Jim Wilson:** Thank you very much for a very comprehensive brief. I have just a couple of points before I ask a question. I certainly agree with your concern about the deinsuring of home care services. What I think people aren't aware of is that of course this is the 20th

service we've seen taken out of medicare since this government came to office. Secondly, it's done for the purposes of allowing user fees to come into the system, because if the services you require don't form part of your plan of service under this act, of course then they are subject, or could be subject, to fees. The government can't get away with that under the Canada Health Act. Therefore it must deinsure those services—sleight of hand, and certainly not something that we're prepared to tolerate in any way from my party.

The other thing is, with respect to the bill being overly prescriptive, I would agree, and think perhaps you agree, that that leads many people to believe MSAs are essentially fronts or window dressing for government policy, certainly, and for implementation of long-term care. I think you allude to that, although perhaps less strongly, when you say certainly people who become part of the MSAs may wonder what in the world they're doing there, because the job is essentially set out in legislation.

I comment on that because of course a previous group here had a couple of very strong words for me. It was Dr Joseph Wong and the Multicultural Alliance for Seniors and Aging. First of all they said no, there was no way MSAs were a government bureaucracy. I would ask him to re-read the bill if he were here.

But secondly, a very, very, very strong, I think, and worrisome almost accusation—I don't want to put words in his mouth—saying that one of the reasons—and he was very clear in response to my question—that MSAs must be implemented as envisioned in this bill and that current systems must be torn down is that people from minority groups aren't able to get home care services now that are culturally sensitive and all the things that are in the language of the bill of rights and that indeed are contained in Bill 101 as already an existing right in this province.

I note on page 4 you have a paragraph that says you're doing your damndest to ensure that your services are culturally sensitive. We're also told by Delores Lawrence, who, for example, was here earlier, that the vast majority of her workers are ethnic minorities and women. I want you to address that, because I don't come from a very ethnically diverse part of the province, so I'm trying to understand this, and I know and I respect Dr Joseph Wong. He's from an area where he's serving a diverse population, yet he's made I think a very strong statement of why there should be MSAs because the current system isn't working for a number of people.

**Dr Daniels:** I come from a highly ethnically diverse part of the province. I'm from Newmarket.

**The Chair:** Hear, hear.

**Dr Daniels:** The issue is to look at the problem first. If there is a problem, then try to analyse the problem and not solve it by a pre-determined solution, because sometimes the solution is worse than the problem was. Not for a moment could anyone suggest that every group in Metro Toronto is receiving services in the form that it wants in the best of all possible worlds. I wouldn't argue with that at all. To suggest, first of all, that proper efforts haven't been made, and in my view a lot of progress made, doesn't fit with the facts. Secondly, to look at the

MSA introduction as it's looking at the moment and to feel some comfort that those concerns would be addressed I don't think fits with the facts as well. So I wouldn't for a moment question the concern, but I would question the solution that's being laid out at the moment. **1610**

**The Chair:** The parliamentary assistant wanted to just clarify one of the points that was made while everyone's here.

**Mr Wessinger:** Yes, I'd just like to make it clear with respect to Mr Wilson's comments, first of all, the services here are not required insured services under the Canada Health Act. Secondly, his comments about deinsuring so that we could charge for the services should be very clear. It's set out in the legislation there's no charge for personal services or home care under the act, and none contemplated.

I think the other thing we should be very much aware of, whatever we call the system of how we deal with the payment, it's the amount of money that goes into the system that's relevant, not the question of whether you call it insured or some other system. Even under the so-called insured system, we've always had a managed system.

**Mr Jim Wilson:** Could I just rebut that? Yes, you are taking an insured service which is guaranteed under the Health Insurance Act, excuse me. Secondly, you do not put a definition in the bill of exactly what you mean by home care. Therefore, it is quite correct to say that some of the services that some groups may now be delivering as home care and that may be covered could very well—and are, as far as I can tell, but if you'd give us actually your financial figures, we'd know exactly what you're going to charge for this act. But I don't trust you. You told us in Bill 101 that—you aren't very forthright with the fees. Yet at the end of the day \$150 million worth of new user fees were introduced into the institutions.

**Mr Wessinger:** It's very clear right under the act what are the categories where regulations can be passed, and certainly there's no authority with respect to the areas with respect to personal care or home care.

**Mr Jim Wilson:** It's not clear to me, and I've been sitting here for weeks.

**The Chair:** I'm going to have to intervene here, because I think there is going to have to be an agreement to disagree, at least at this point, while we move forward. I regret that time is always our enemy and I want to thank you both. I'm delighted, Dr Daniels, to learn that we live in the same municipality. I want to thank you both again for coming before the committee and for your presentation today.

#### ONTARIO ASSOCIATION OF OPTOMETRISTS

**The Chair:** I call upon the executive director of the Ontario Association of Optometrists. Actually, I don't think this is—somehow—

**Dr Mira Acs:** Somehow you don't think so, right?

**The Chair:** The name just doesn't fit.

**Dr Acs:** No, it doesn't fit. Greetings.

**The Chair:** But you are none the less welcome. Every

now and then the Chair has to decide, should I sort of indicate who it is before I ask them to introduce themselves, and I blow it every time.

Let me start over again. I now welcome the representatives from the Ontario Association of Optometrists. If you would be good enough to introduce yourselves, we have a copy of your presentation, and please then go ahead. I would just ask others if they could perhaps carry on their discussions outside, just so we can have a little peace and quiet. There. Please go ahead.

**Dr Acs:** Good afternoon. My name is Dr Mira Acs. I'm the president of the Ontario Association of Optometrists. With me today is Barbara Wattie Fuller, who is the director of policy and government relations.

The Ontario Association of Optometrists is a voluntary organization which represents the profession of optometry in this province. In our membership, we have more than 92% of those registered to practice our profession in this province.

The proposal by the Minister of Health, the Honourable Ruth Grier, to amend the means by which important core services are provided to certain clients of the ministry must in the first instance be recognized for its important attempt to simplify the access mechanism for those who qualify. This act, when implemented, will ease the burden presently facing some clients and their families as they try not only to find what services are available but also the steps required to establish eligibility for receiving those services. Members of the Legislature have all no doubt been frequently requested to assist constituents in need with respect to finding and obtaining these important services.

A second and equally important aspect of the legislation is the inclusion of a bill of rights for those who receive services under the provisions of the act. The provision of this section does no more and no less than state the absolute moral imperatives which must be inherent in the provision of any and all health and life care and services in Ontario. This progressive facet in this legislation is worthy of mention and praise.

Few are those occasions when legislation is so perfectly crafted that not even one individual group is able to think of even one amendment which they feel would enhance the bill. Others have presented their specific views, and we too find that there are two further specific areas which we suggest are worthy of reconsideration.

The first relates to the provision in paragraph 56(1)30 which gives the minister powers with respect to qualifications of providers under the legislation. It may well be that the drafters did not intend to infringe upon the powers of colleges under the Regulated Health Professions Act, the RHPA. However, we are concerned that without further consideration, a potential will indeed be created which will give rise to an infringement upon the powers granted under the RHPA, particularly with respect to the powers of individual colleges to regulate specialties and forms of registration.

To this end, we suggest that the present draft be amended so as to identify clearly and to confirm the role and power of the colleges under the RHPA with respect

to the qualifications of their members or, alternatively, be amended to exempt members of the health professional colleges from this section or, and this may be the most efficacious option, to identify those individuals or groups of individuals whom it is intended to cover.

To some, an act to govern the provision of long-term care might seem a curious place to include significant amendments to the existing legislation governing district health councils. In particular, this point of view will be held by those for whom a comprehensive and fully consultative review of the concept and role of these councils is regarded as a more needed and more appropriate approach. Such an opportunity now being present, the inclusion of the present amendment provides the opportunity to comment on some specific areas with respect to the governance of the DHCs.

The amendments at hand speak to the composition of DHC membership as it relates to the specific diverse community which each represents. However, the principle of representative composition is dealt with in a very narrow way. There is still no requirement that council memberships represent a balance of providers and consumers. If changes are deemed to be needed to require participation in membership in the manner outlined in this bill, then this is the time to establish balance in other areas as well, including the need to ensure that councils are neither institutionally nor medically dominated or oriented in their composition.

There will be, no doubt, representations from those who have concerns about those services which are not specified under the legislation. These in part are services which may or may not be added by regulation. These include the addition of one or more groups of professional providers, specifically some regulated professionals.

There are two areas of concern here that are readily apparent. The first is that additions will be on an MSA-by-MSA basis. Either the type of care is required in this province or it is not. It is not somehow required in region A and superfluous in region B. Such a discrepancy strikes at the philosophical heart of any universal program in this province. The challenges to citizens in Ontario that arise from the optional provisions under local social assistance programs should clearly indicate to members of the Legislature why this is not a desirable mechanism in the present instance.

The second concern is that some key service provisions in the form of health care services have either been omitted in error or for reasons as yet unrevealed. Other groups must speak for themselves, but for optometry we say that consideration should be given as to how clients, especially those who are not easily able to leave their residences, will receive the diagnostic and therapeutic vision care that is so important to their continued optimum enjoyment of life.

The Ministry of Health includes optometric diagnostic services as part of the schedule of OHIP benefits. This does not, we trust, preclude future contractual arrangements under which a full range of services, both diagnostic and therapeutic, might be provided on other than a fee-for-service basis and we regard the MSA as a promising vehicle for developing alternative forms of payment

mechanisms. Therefore, we suggest that the act must permit and indeed encourage MSAs to make arrangements which facilitate the inclusion of present fee-for-service providers either in traditional or in new forms of compensation so that they may thereby enhance the range of services rendered and the quality of life of those who are intended to benefit from the provisions of this new legislation.

1620

**The Chair:** Thank you very much. I note for the record that you've summarized your recommendations at the end as well.

**Mrs Sullivan:** I have two questions, both of which I'm going to direct to the ministry, arising out of your presentation, which I think is an interesting one in that it's covered some areas that have not been talked about so far.

The first is with respect to the qualifications of providers under the legislation and the concern that is being raised, not only by the association of optometrists but by one or two other professionals, with respect to the RHPA and its role and the qualifications of providers under this legislation, in particular the qualifications of the new generic worker, whom, we understand, training courses are now being conducted for and so on. I'd like to know, first of all, what respect will be provided to the disciplines under the RHPA and, secondly, how a generic worker could perform some of the acts that are required to be performed by a professional.

The second issue that I wanted to raise is also raised here, and that's with respect to the fees of professionals when those professionals operate under a fee-for-service system. Under this act, would those fees then be part of the 20% that the MSA can purchase outside? Would there be then, if the 20% is used up, a situation that could occur where, for instance, there could be no eye tests done, whether they're needed or not, there could be no medical services purchased, whether they're needed or not, just because the organization has run out of the 20%?

**Mr Wessenger:** I will perhaps attempt to answer those questions, and then I probably will refer it to legal counsel on the first question, but my understanding is, for instance, the Regulated Health Professions Act will prevail, and obviously you couldn't prescribe any requirements contrary to that act.

Secondly, with respect to fees for professionals, obviously, if they're covered by OHIP, that would be the method that they would be covered in their compensation, for instance, in the situation of optometrists.

**Mrs Sullivan:** You see, that's where part of the problem is, because there is confusion—I'm certainly confused about it, and the last exchange didn't alleviate that confusion—about what OHIP will cover under the new act and what it won't cover under the new act, whether it's in terms of professional services or whether it's in terms of services that are now covered under the home care program that may or may not be covered under the long-term care bill.

**Mr Wessenger:** I think it's quite clear that if a

service is not covered under OHIP, then it would have to come out of the purchase of services by the MSA. It should be noted, however, with the purchases from an individual it's not part of the 20% limit. In the case of most professionals, it would be a purchase of service from an individual.

**The Chair:** We'll go to legal counsel, and then if you have perhaps further questions arising out of that, I'll come back to the presenter.

**Ms Czukar:** With respect to the issue of qualifications of service providers, what the regulation-making power says is that we can make regulations requiring that service providers have certain qualifications or meet certain requirements and prescribing what those would be. The intention there would be clearly that, if optometric services were going to be provided, they be provided by an optometrist as qualified under the Regulated Health Professions Act.

In other words, this would refer to those acts, and clearly any acts that are required by those acts to be performed by qualified professionals and aren't delegable to others couldn't be performed by generic workers and wouldn't be performed by generic workers. The regulation-making power here is just to ensure that where service providers are going to be performing those services, they have the requisite qualifications under whatever the applicable statute is. In any case, you couldn't override whatever is required under the regulated health professions legislation by a regulation under this act, because statutes always prevail. So the intention here is to provide the vehicle for prescribing what qualifications people would need to properly do their jobs.

**The Chair:** Any comment on that?

**Mrs Sullivan:** Well, I suppose just on the 20%. Basically, what the parliamentary assistant is telling us is that services which are provided individually, if they are professional services, will be paid for over and above the 20% limit under this bill. If, however, you have a professional who is working in, let me see, say an HSO situation, which optometrists could be involved in in some cases, or in a joint practice or in a community health centre, would they be limited to the 20%? What's the rationale for the distinction?

**Mr Wessenger:** I think you're probably correct there, but I'm going to ask Mr Quirt to comment on this and perhaps also on the generic worker aspect.

**Mr Quirt:** First of all, if someone needed an eye exam they'd be referred to an optometrist and the optometrist would bill OHIP the way they do now—whenever I get my eyes checked or you get your eyes checked—so that's not going to change at all. The services that home care now delivers and the home care budget pays for, like nursing and physiotherapist services and so on, have been funded indirectly under the Ontario Health Insurance Act to date. There's no requirement that we provide those services as insured services, and there are two provinces left in the country that do consider them insured services.

Even though they're historically considered insured services, home care programs get a budget each year and

try to manage within that budget, and as pressures exist for emergency services like hospital replacement services, the government responds accordingly.

When it comes to the 20% rule, the 20% rule is designed to limit the extent to which those programs and services that the MSA budget covers, services like nursing and homemaking, how big a contract they could have with a private provider or the Red Cross or the VON to buy homemaking and nurses' services. If, for example, a client of the MSA needed a service from a specialist that couldn't bill OHIP—and I'll use a psychologist as an example—then the MSA can go ahead and buy the services of that psychologist and that doesn't count towards the 20% limit in terms of their contracts with other service provider agencies.

I hope I've clarified it somewhat for you, but with respect to physician services or anybody else you can bill to OHIP, including optometrists, that doesn't change at all, and the role of the multiservice agency would be to identify if a client has a vision problem and make the appropriate referral to have that checked out, if in fact the family physician hadn't already done that.

**The Chair:** Did you have a query on that?

**Dr Acs:** I was just going to clarify that for the purposes of optometric services, the diagnostic component of optometric services is billable to OHIP, but the therapeutic component, whether it's the provision of glasses or low-vision aids or spectacles or contact lenses, is not. So of the full-scope optometric service, only the diagnostic component in fact is covered. The other components are not, so we do fall into both.

**The Chair:** As was noted earlier, you have raised some areas that we haven't looked at as closely and we appreciate it.

BARBARA WAHL

**The Chair:** I call upon our final presenter to come forward, Barbara Wahl. While you are the final presenter, we welcome you as much as we did the first presenter and also appreciate that you've come, I think, from Waterloo.

**Ms Barbara Wahl:** Yes, I have.

Ladies and gentlemen, I'm coming to you at the end of a long series of consultations. I'm sure you've heard more than you want to hear. As a registered nurse who's been involved in the community for over 20 years, I believe I have an accurate picture of the health needs of the community. I look at this from the perspective of a member of the district health council, as a consumer, as a provider for aging parents as well as a home care case manager.

I believe the principles of the MSA to be sound. Certainly there is a need for a central point of access. In some communities, this has existed for a long period of time through the Ministry of Health funded home care program. Integration of more services and responsiveness to individual needs are certainly excellent fundamentals. However, as this new vessel, the MSA, ventures into expanded territories, it becomes clear that direction for clients is required. This has been the role of case management in the community health area for over 25 years.

In order to help you understand the importance of case management, I'll ask you to join me in a day of visits with a case manager.

A case manager assesses and maintains services for approximately 120 people. This includes services, equipment and supplies and would include a multitude of services such as physio, nursing, occupational, health, social work, speech therapy, nutrition and homemaking and on and on. The degree of case management that's provided is directly proportional to the needs of the clients. Thus, an individual post-operative client might require only a little bit of service, while a senior who has reached a crisis situation might require extensive help.

#### 1630

If we go to visit Mr A, a new client referred by a physician, he lives alone in a rooming-house without cooking facilities. He walks five kilometres a day but appears unkempt and very thin. A case management assessment was made. He's satisfied with his level of care. His income is stretched and therefore the case manager, with his permission, registers him for meals at a senior program and much-needed foot care.

Most important, future plans and possible options are discussed. No further intervention is needed or planned at this time, but Mr A has a contact if he should require help later and background information is available for him.

Miss B, at 85, has Alzheimer's disease and her main care giver is her sister who is 87. These two ladies have had case management and home care support for two years. Initially, homemaking was set up to help with personal care, meal preparation, housekeeping, laundry and to provide support to the sister. Frequent, close monitoring has led to an increase of services, such as day away care for Miss B and a regular senior program for Miss C. At the current visit, case management increased homemaking to every morning to assist Miss B with morning activities and get her on the bus for day care. Future plans are discussed with Miss C as Miss B's confusion, wandering, incontinence and striking out are causing Miss C to consider placement. Much recognition was given to the sister for her incredible dedication and contact was made with placement coordination services.

Mrs D, at 82, has an acute, two-month history of repeated labyrinthitis, causing extreme dizziness. At this visit, she and the case manager agreed her state of health was much improved. Homemaking services were reduced, with the client's full support, from four to two times a week. Reassurance was given that the service would be increased if necessary. Of note is that her service provider had not volunteered that the level of service was more than the client needed and the savings that would be accrued to the system would be about \$1,500 a year.

Mrs E, at 42, has a 10-year history of multiple sclerosis. She lives with her husband who works a 12-hour day. The home is being renovated. On discussion, the case manager finds out that the client has not been out of the home for months. She can no longer get her wheelchair over the stoop, but she does have an outside ramp. Planned renovations are not practical for someone in a wheelchair. Mrs E confesses her marriage is stressed. The

case manager arranges to have occupational therapy to do an assessment of the renovations and her activities of daily living, to have a social worker provide counselling and to have a physiotherapist assess and treat a knee contracture which is developing. Homemaking is also increased slightly so that the homemaker can assist this client to get over the stoop and down the ramp and go for one walk a week. The client was encouraged to ask for help as needed. Frequent visits are planned due to her reluctance to ask for help and her currently acute problem.

Mr F is currently needing wound dressings three times a day in preparation for surgery. After assessment, it was decided that he would do dressings twice a day and the VON was arranged for once, including monitoring. Mrs F turned out to have cardiac problems and complained of stumbling and falling. Permission was given for the case manager to call her physician because she said she forgets everything when she goes to see him. Other services were not required at this time. Savings at the rate of two VON visits being saved each day would come to \$23,000 a year.

Baby G, 18 months old, was born with a haemangioma of the throat, necessitating a tracheotomy. Medical treatment by a team of professionals is complex, but almost of it has been taught to the family. However, there are two other small children and the parents are very stressed. Support in the form of overnight nursing care was arranged. The family was also tied in with local peer supports.

Mrs H had been receiving homemaking services, but because her health had improved, she's now independent with personal care, was using the homemaking services as a cleaning service and did not meet the criteria of the home care program. Services were terminated and other alternatives were suggested. A time was arranged for the case manager to telephone to make sure she was managing. Savings, about \$750 a year.

Mrs I, at 87, although blind, lives in her own home and is determined to stay there. She started with a half-day of homemaking and now has it twice a week. A VON nurse has been visiting weekly to pour medication, but even this has caused the client great difficulty because of her lack of vision and her arthritis which caused frequent spills of medication. Therefore, the case manager arranged with the pharmacy for weekly delivery of prepackaged blister packs for medication. VON services were discontinued until further needs arise. The savings would be over \$2,000 a year.

Finally, Mrs J lives alone with two small dogs. She's frail and requires help with personal care, meals, laundry, housekeeping. She frequently calls police and a distant relative because she feels people are coming through the walls. Recently, she lost her budgie. A homemaker found it on a plate in the freezer. Homemakers are refusing to visit this client because she yells at them constantly and will not allow them to help her in any way. Mrs J is not eating. The case manager discussed the situation with the physician and the relative. Immediate placement was arranged through placement services and a home was found for the dogs.

These clients are typical of any given day. The situ-

ations speak for themselves. Even a simple case may require complex intervention if there are no supports. In each case, successful intervention was achieved because a team approach was used, with the case manager acting as a leader-facilitator. The case manager upheld the principles of client autonomy, matching the degree of intervention to the needs and wishes of the client and maintaining cost-efficiency for the province.

In all these cases, the service providers were not able to deal with the problems at hand in addition to carrying out their services. In many cases, the direct service providers did not have the education or experience to make appropriate decisions. This will be even more true as we see the proliferation of the generic worker who has little education in health care and only basic training. This worker will be on a one-to-one basis with the client, but without case management the client will not have access to the multitude of needed resources because the basic worker will not know about them. Cost of care will in fact escalate. In all cases, the service providers were in a conflict-of-interest situation as reducing the number of visits would have reduced their work and thus their income.

As a member of the DHC in Waterloo, I applaud the quality assurance and cost containment of case management. As a provider of care to elderly parents, I appreciate being able to speak to one well-informed and resourceful person about their case. I can depend on that person to assess the situation, make recommendations, implement the appropriate course of action and monitor the situation as appropriate. Finally, as a taxpayer I recognize that initiating the correct care at the time of need will in fact save dollars in the long run.

In Bill 173, case management is not even mentioned. I believe it to be an essential component of the MSA. In Ontario, case management has been an integral part of the home care program of community health for 25 years. There are 1,700 case managers currently providing the type of services which I have outlined. Other parts of the world are looking at our model as a model of excellence. I believe this government does have the insight to take advantage of the service of case management by building it into the MSA of long-term care.

**The Chair:** Thank you very much and particularly for all of the examples that you have provided to us.

**Ms Carter:** I think you've given us a very eloquent and personalized account of what case management is all about. I don't think you really needed to sell that to us; I think we understand that. I'm sure that case management is in fact an integral part of what we're planning. I'm just looking at section 20 of the act, which talks about how when a person applies to an agency for community service, the person shall be assessed.

**Ms Wahl:** Yes, it refers to case coordination.

**Ms Carter:** Yes.

**Ms Wahl:** But case coordination is not the same as case management. Case coordination is a very small part of case management. Case management has an ongoing monitoring role and ongoing assessment, recommendations and so on.

**Ms Carter:** So you're saying that that is not explicitly provided for.

**Ms Wahl:** That's right.

**Ms Carter:** I guess, when you have an act, not everything is in there and sometimes it can be counterproductive to put too much because sometimes, by adding words, you limit rather than allow freedom.

**Ms Wahl:** I think it's really important that the full component of management be built into this, rather than just coordination of services, because only if there is someone who is driving the boat are we going to be able to achieve savings and monitor situations, increase services as necessary and so on.

**Ms Carter:** Could I ask the experts whether they feel that case management is somehow embodied in what we're doing?

**Mr Wessinger:** I think if we look at section 20, it's certainly the opinion of legal counsel that everything is embodied in that because it sets out, for instance, the responsibility to assess the person's requirements; determine the person's eligibility for the services; develop a plan of service for each person determined to be eligible; review the person's requirements when appropriate, depending on the person's condition and circumstances; and revise the person's plan of service as necessary.

I'd certainly be interested in knowing what might be lacking from that. I know that legal counsel would—since you've asked me the question, I might just throw out a question, if I might get away with it. Certainly, case management is an essential function of the services. But what about those situations where somebody perhaps just needs a meal; do you feel that you need such extensive assessment?

**Ms Wahl:** No.

**Mr Wessinger:** No, so it could be, as long as the case management is there for the—

**Ms Wahl:** Absolutely not. But, you know, it's very seldom that someone just needs a meal. I do that all the time; that kind of assessment is made on the telephone. But it's not as simple as just saying that he needs a meal or he doesn't, because why does he, and if he needs a meal, what else is wrong?

**The Chair:** Did you wish to comment on section 20?

**Ms Wahl:** I realize that that is there as such, but it's very important that it be identified as case management because it needs to be done as case management by someone other than the service provider, who has a vested interest in maintaining services, and by a case manager, who's a professional who has a broad-based knowledge of what's required.

**The Chair:** You've raised a number of questions, and while it is at the end of the afternoon, we appreciate you coming before the committee and, as I said before, particularly for the examples of what a case manager does.

Committee members, we stand adjourned until tomorrow morning at 9 o'clock in Kingston in the Ontario Room of the Ambassador Hotel.

*The committee adjourned at 1643.*





## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

**\*Acting Chair / Président suppléant:** McGuinty, Dalton (Ottawa South/-Sud L)

**\*Carter, Jenny** (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

**\*Martin, Tony** (Sault Ste Marie ND)

**\*O'Connor, Larry** (Durham-York ND)

O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Conway, Sean G. (Renfrew North/-Nord L) for Mrs O'Neill

Malkowski, Gary (York East/-Est ND) for Mr Hope

Sullivan, Barbara (Halton Centre L) for Mr Eddy

Tilson, David (Dufferin-Peel PC) for Mrs Cunningham

Wessenger, Paul (Simcoe Centre ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Czucar, Gail, legal counsel

Quirt, Geoff, acting executive director, long-term care division

Wessenger, Paul, parliamentary assistant to the minister

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Boucher, Joanne, research officer, Legislative Research Service

# CONTENTS

Tuesday 13 September 1994

<b>Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,</b>	
projet de loi 173, <i>M<sup>me</sup> Grier</i> .....	S-2107
Association of Ontario Physicians and Dentists in Public Service .....	S-2107
Dr Martin Chisvin, board member	
Dr Michael Kugelmass, board member	
Dr Jansz Duktia, president	
Christian Labour Association of Canada .....	S-2112
Ray Pennings, national representative	
Hank Beekhuis, Ontario representative	
Ontario Psychological Association .....	S-2116
Dr Ruth Berman, executive director	
Dr Mary Tierney, chair, task force on long-term care	
Victorian Order of Nurses, Ontario division .....	S-2119
Fay Booker, volunteer	
Gale Murray, executive director	
Regional Municipality of Waterloo .....	S-2122
Ken Seiling, chair	
Phil Johnston, commissioner, social services	
Elizabeth Leeson .....	S-2125
Kidney Foundation of Canada (Ontario); Canadian Association of Nephrology Social Workers (Ontario) .....	S-2127
Janet Bick, provincial advocacy coordinator, Kidney Foundation	
Lisa Bletcher, representative, CANSW	
African Canadian Entrepreneurs .....	S-2130
Delores Lawrence, president	
Regional municipality of York .....	S-2131
Eldred King, chair	
Dr Helena Jaczek, medical officer of health	
Peter Crichton, commissioner, community services	
Multicultural Alliance for Seniors and Aging .....	S-2134
Dr Dimitrios Oreopoulos, president	
Dr Joseph Wong, vice-president	
Canadian Mental Health Association, Ontario division .....	S-2136
Carol Roup, senior director, policy research and branch services	
Ruth Stoddart, executive officer	
Lisa McDonald, community mental health consultant	
Home Care Program for Metropolitan Toronto .....	S-2140
Marian Walsh, president and chief executive officer	
Dr Phil Daniels, board chair	
Ontario Association of Optometrists .....	S-2144
Dr Mira Acs, president	
Barbara Wahl .....	S-2146



## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Wednesday 14 September 1994

# Journal des débats (Hansard)

Mercredi 14 septembre 1994

## Standing committee on social development

Long-Term Care Act, 1994

## Comité permanent des affaires sociales

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Wednesday 14 September 1994

Mercredi 14 septembre 1994

*The committee met at 0906 in the Ambassador Hotel, Kingston.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS  
DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Chair (Mr Charles Beer):** Good morning ladies and gentlemen. The standing committee on social development is now in session. We're very pleased to be here in Kingston today to review Bill 173.

JOINT LIAISON COMMITTEE  
OF THE ACADEMIC HEALTH SCIENCES CENTRE  
OF SOUTHEASTERN ONTARIO

**The Chair:** We have a very full day with many presenters, so we'll move right to our first presentation by the joint liaison committee, if the representative of the joint liaison committee would come forward.

Mr Rosenbaum, welcome to the committee. We have 20 minutes. If I could just say to you and to others in the room, because of the number of presenters, we wanted to make sure we heard from everyone, which means that on our side we limit our questioning in most cases to just one member per presentation. We'd like to be able to spend more time, but we felt it more important to hear what you have to say. We can debate these issues in the Legislature.

**Mr Paul Rosenbaum:** I'll take about 10 minutes, and then if there are any questions, I'd be pleased to answer them.

The Joint Liaison Committee of the Academic Health Sciences Centre of Southeastern Ontario comprises Queen's University, the Kingston General Hospital, Hotel Dieu Hospital, Providence Continuing Care Centre, which operates St Mary's of the Lake Hospital and Providence Manor, the Kingston Psychiatric Hospital and the Kingston, Frontenac and Lennox and Addington Health Unit. The joint liaison committee, or JLC, is a voluntary association of the university faculty of medicine and its principal teaching institutions. As such, the JLC is concerned with the provision of health services, the education of future health professionals and research related to health and health care. We're very pleased to have this opportunity to participate in these hearings on Bill 173, the Long-Term Care Act.

I think it might be asked why an association of large institutions—a medical school and its teaching hospitals—is interested in a bill which addresses community

health programs. The JLC has for a significant period of time recognized the importance of a health system which balances the need for institutional care and the need for community services.

In our brief we will address three aspects of the bill: The first is multiservice agency sponsorship; the second is what we view as possible threats to the specialized community health programs which have developed; and the third is the purposes of the act. We believe these three issues can be easily addressed with very modest modifications to the act.

First, with regard to sponsorship, for reasons which are not made clear in the compendium, the act places significant restrictions on the ability of a board of health to be designated as a multiservice agency. The act reads:

"Before designating a...board of health as a multiservice agency for a geographic area, the minister shall consider the suitability of all other approved agencies in the geographic area for designation as multiservice agencies."

This restriction is inexplicable, and we believe, in the case of this health sciences centre, contrary to good sense.

First, even without this additional impediment, the board of health would still have to meet all the requirements of a multiservice agency. Failure to meet all the requirements, including that of a governing board which is representative of the community, would disallow any agency, including a board of health, from becoming an approved agency under the act.

Second, even as an approved agency, that is, an agency which meets all the requirements, a board of health would still have to compete with other approved agencies for designation as a multiservice agency.

Why is this sponsorship issue of concern to our members? According to the Ministry of Health's own equity data, our two acute care hospitals are the most efficient teaching hospitals in their peer groups; that is, they have the lowest costs per weighted case. We believe one of the reasons is a very close relationship which has developed between the board of health and the hospitals, and this relationship has fostered the growth of a remarkably strong and aggressive home care program. Our hospitals are concerned that a change in sponsorship of the home care program may jeopardize this relationship. Will a new agency understand the needs of the hospitals and their patients? Will a new agency sustain the growth accomplished by our existing program? We have all heard the adage, "If it ain't broke, don't fix it." We

believe that this health sciences centre should serve as a model for hospital-community care relationships. Instead, the act may threaten the continuation of this exemplary relationship.

How to address this problem: We think the solution is simple. The bill should have subsection 11(3) deleted, thereby imposing no restrictions on the designation of boards of health as multiservice agencies. This doesn't mean automatic designation, but it means boards of health could compete equally in designation as a multiservice agency.

The second issue I'd like to discuss is potential threats to specialized community health programs. Under subsection 11(4), the act allows for the designation of more than one multiservice agency within the same geographic area. We believe this can threaten the continued existence of specialized community-based programs which have developed in this health sciences centre.

In order to affect earlier discharge, we have worked jointly to develop specialized services in the home care program. Often these specialized services are provided by a very small number of professionals. With multiple multiservice agencies, how would we divide existing home care staff? If there's one physiotherapist specialist in a particular specialty service, to which multiservice agency would he or she go?

Specialty services require a critical mass. As we move in this centre towards increased specialization, critical mass has become an issue. Dismembering the existing home care program and dividing it among more than one multiservice agency would not only discourage further specialization but will jeopardize that which now exists.

How can this be addressed? Subsection 11(4) of the bill, which allows for designation of multiple multiservice agencies, could be amended. The act should only allow for designation of more than one multiservice agency within a single geographic area under extraordinary circumstances. Where it can be demonstrated that more than one agency will be more effective or more efficient, the act should be permissive, but it should not allow dismemberment without some compelling reason to do so.

The last issue I'd like to discuss is that of the purposes of the act.

We support strongly the purposes of the act specified in the bill. Indeed, the very behaviour of our members over several years attests to our support for these principles.

Our concern is that the purposes are somewhat narrow. They fail to recognize the absolutely essential academic role of community-based health care.

If our health care system is to improve, to become more efficient and more effective, it's necessary to address the education of future health professionals. Locally, our members are doing just that. Our home care program, under the sponsorship of one of Ontario's teaching health centres, has become a training site for physicians, occupational therapists, physiotherapists, dietetic interns and nurses. Will a new multiservice agency recognize this critical need?

We do not believe that this should be left to chance.

Just as teaching hospitals have all developed affiliation agreements with medical schools, multiservice agencies within Ontario's five health sciences centres should be designated as teaching agencies whose legislated mandate includes education of future health professionals and programs of health-related research. We have in Ontario a nascent academic program in community-based health care. This program should be supported, and Bill 173 is silent on this.

How to address this problem: The purposes of the act, part I, should be amended to include the development and support of programs which educate future health professionals within community-based health programs and the development and support of research programs in community-based health care. The act should explicitly allow multiservice agencies to become teaching agencies and should require this within the geographic areas in which the five Ontario health sciences centres are located. Teaching multiservice agencies should develop, in collaboration with educational institutions, programs of exemplary service so as to educate future health professionals and programs of community-based health care research.

**The Chair:** Thank you very much for the presentation. I would note as well that you have left with us a newsletter entitled Board Talk.

**Mr Rosenbaum:** That actually is a testimonial from an independent organization which studied the joint liaison committee. That's the advertisement.

**The Chair:** The verification.

**Mr Rosenbaum:** That's right.

**Mr Gary Wilson (Kingston and The Islands):** Let me, on behalf of the riding of Kingston and The Islands, welcome the committee to our area. It's certainly a pleasure to be hosting these hearings into this very important subject, and, Paul, welcome to the committee. I think you've already given a good indication of the importance the JLC has in our area and I think will be representative of the others that we hear. But I'm especially pleased to see you because you can offer a good overview of the various health care services we have and where the multiservice agency will fit into that.

Listening to your remarks, I would turn back to the first part, I suppose, to where you discuss the role that the home care program has played here. I'm wondering if you could just elaborate on why you think it has been so successful here. What parts of it have been, I guess, developed here, in your experience, and how could it be a model for multiservice agencies across the province?

**Mr Rosenbaum:** I think the home care program has been particularly successful in this community. The evidence shows remarkable growth in the home care program, I think growth which probably matches or exceeds any other home care program in the province. Our hospitals believe part of the reason for their efficiency is this growth.

In fact, two years ago, when we had a fairly significant bed reduction in our acute hospitals, the number of patients served over the first 12-month period increased, didn't decrease, and in fact the number of inpatients

marginally decreased, with much shorter lengths of stay.

The relationship between the home care program through the health unit and the hospitals is a very close one through membership on the joint liaison committee. In fact, our hospitals have voluntarily transferred funds to the home care program on a number of occasions to sponsor pilot projects. Two specialized programs that come to mind include the placement of case workers in the regional cancer centre and the placement of a case worker in obstetrics. These were originally funded by the hospitals, although they were home care projects.

We have a home care program which has conducted a study of palliative care and a study of the interface between the community and hospitals. Although these studies were conducted by the home care program, they're again funded by the hospitals.

**Mr Gary Wilson:** Paul, if I may just interrupt there to ask you where the ideas for these new programs come from, is that done in relation with the home care program? Does it come from the need that's been identified by the hospitals, for instance? In other words, what I'm getting at here, I guess, is, how can we develop the programs we'll need for community-based care and just where do these ideas come from for the kinds of programs we'll need?

**Mr Rosenbaum:** They come from a wide variety of sources, Gary. They come from the institutions recognizing certain needs that can be best met in the community, from the home care program, from the literature, in fact from government policy directions as well. I don't think we can identify one source.

I think the point I'm trying to make, though, is that part of the strength of the system here is the high degree of collaboration. We have tried to operate as though we were a single system. In fact, part of our concern is that we believe for a variety of reasons we can easily get ahead of government in this.

0920

If you look at the way government does budgeting, for example, we have separate budgets not only for different ministries but within ministries, different votes. In some ways, that acts as an impediment to us. The equity funding data show that our hospitals are underfunded compared with any other hospital in the peer group. It hasn't been as much of a problem as it could have been if we didn't have a strong home care program, but now suddenly home care is capped, and we're concerned about how the home care budget will affect the hospitals. That is, we don't have a single envelope.

So we do our best to operate as a system, but there are impediments, and I don't think these are unusual to this province.

**Mr Gary Wilson:** As you know, the multiservice agencies are partly designed to use money more efficiently. Do you think this is one of the solutions, or at least will help relieve the pressure?

**Mr Rosenbaum:** Well, we all have to use money more efficiently, I think, now and in coming years. Certainly giving the stronger tools to agencies concerned with placement and treatment will have the capacity of

increasing efficiency. Whether that happens or not I think in part depends on the will of those people who run the agency and their relationship with others.

**The Chair:** Last one.

**Mr Gary Wilson:** Just one last one? Paul, what is your sense of the provincial scene here, as far as eastern Ontario and in particular our area? Have you got a sense of what other areas are like and how we compare with them?

**Mr Rosenbaum:** I think the testimonial from that centre on governance—I'd rather have them speak for us. They say that we are a model for all of Canada. I agree, but it's nicer to have an independent body say that.

**The Chair:** Thank you very much. I know one of the things that's very interesting as we go around the province, for those of us who aren't from those areas, is getting a better sense of exactly what is going on and your presentation this morning has been most useful.

#### HASTINGS AND PRINCE EDWARD COUNTIES DISTRICT HEALTH COUNCIL

**The Chair:** I call the representatives from the Hastings and Prince Edward Counties District Health Council.

**Mr Alan Mathany:** I'm Alan Mathany. I'm the chair of the district health council for Hastings and Prince Edward Counties. We also have with us today Barb Jones, who's the vice-chair of the long-term care committee; Steve Elson, our executive director of the district health council; and Jeanne Thomas, our health care planner in long-term care.

As I indicated to you, my name is Alan Mathany. I'm chair of the district health council and have been since its inception in 1991.

Our presentation will be in two parts. One will deal with the part of the Long-Term Care Act which deals with the generic role of DHCs. The other will comment on the implications of the act on our long-term care planning work and on our long-term care planning committee in particular. I will speak and will direct my comments to section 62. Barb Jones, vice-chair of our long-term planning committee, will speak next and will talk about the impact of the act on long-term care planning from our point of view.

First of all, I'd like to say that we are encouraged by and welcome the inclusion of this amendment to the Ministry of Health Act. It gives a clear message of support on the part of the Ministry of Health for the work of district health councils in a way which has not been present before.

We'll deal with the subsections in order.

Subsection (1) codifies the existing situation in that the minister already specifies the geographic areas for which each district health council is responsible for planning health and health care services.

I would simply like to note that in practice, planning by DHCs cannot be defined by political or geographic boundaries but has to be sensitive to the actual patterns of service use which take people outside our boundaries as well as bring people into our district. The need to improve inter-DHC planning mechanisms which

recognize these realities is something we see as being important.

Subsection (2) reaffirms the existing situation in that members can be appointed by the Lieutenant Governor in Council or minister, and we really have no comments to make in regard to this.

Subsection (3) states that the government shall consider the importance of ensuring that the membership reflects the diversity of the population in the council's geographic area. This is something we support. However, given the limited number of district health council members and the assumption that the balance among consumer, providers and municipal members will continue to be present, this could impose serious limitations on the ability of DHCs to comply, depending on how prescriptive this expectation is.

In our particular situation, we are striving to maintain a balance of male and female members, and we select most members from six defined geographic areas within our district to reflect the geographic diversity of our district. We obviously have to select candidates who volunteer and are willing and able to fulfil the duties and responsibilities associated with DHC membership, regardless of what other characteristics and experiences they bring forward. As long as these expectations concerning diversity are presented as guidelines, we will do what we can to ensure that the most able people are recommended to the government. We would be uncomfortable if we had to target specific groups or persons and thereby exclude others from the opportunity to participate as council members.

Subsection (4) spells out the functions of district health councils and defines the generic role of each DHC. The functions outlined are familiar ones and reflect our current work. However, while the functions define the accountability of DHCs to the Minister of Health, they do not reflect the responsibility DHCs have to their community and the reality that this responsibility reflects an important aspect of DHC life, especially in the current climate where there are at times important differences between what the Ministry of Health would like to see happen and what communities are prepared to accept.

This squeeze play, so to speak, puts DHCs clearly in the middle, and it would be helpful if the functions of DHCs affirmed this aspect of our work. The functions of a district health council, as stated, could be expanded to include a clause which reads "to respond to health planning issues identified by citizens in the council's geographic area."

I would also like to point out that the functions of district health councils relate to the collective abilities of all DHCs as well as to individual ones.

The work of DHCs is evolving. Part of this evolution involves the shift from a focus on formal, structured planning processes and report production, following a prescribed methodology, to more innovative, flexible planning approaches, a strong focus on implementation planning and giving local leadership to the process of change, which is consistent with the government's vision of health. In this regard we see the functions outlined in the legislation as generic ones, with the understanding

that new functions and new applications of these functions will continue to emerge.

Subsection (5) deals with aboriginal communities. The Tyendinaga Mohawk territory is part of our district, and preliminary conversations and exchange of correspondence has taken place regarding the role of district health councils. We assume that the anticipated aboriginal health policy statement will spell out the implications of this clause more clearly. Meanwhile, we support the statement as it has been prepared.

Subsection (6) concerns service providers making plans and information available. Can we interpret this clause to also mean that if there are situations in which the DHC asks for planning-related information which a provider is unwilling to provide, the DHC, through the ministry, can ask to have this information made available? I say this simply because legislation tends to reflect exceptional rather than ordinary circumstances, and I wanted some clarification in regard to this clause.

I would like to add that we have enjoyed a collaborative working relationship with the Ministry of Health and expect that DHCs will be active partners in the development of all regulations and policy guidelines which will affect the way we operate.

Those are all the comments I have to make at this time. As I said at the outset, we are supportive of the general direction outlined in the legislation and have brought forward our comments and questions as a reflection of the realities in which we are operating at the present time.

I thank you for your attention. Now I'd like to ask Barb Jones to speak to the long-term planning committee issues.

**0930**

**Mrs Barbara Jones:** Thank you, Alan. As Alan mentioned, my name is Barbara Jones and I've been the vice-chair of the long-term care planning committee of the district health council since October 1993. This is the first planning committee for long-term care issues at our DHC, and I'm a consumer representative.

The long-term care planning committee also supports the principles of the Long-Term Care Act, 1994, Bill 173. However, the committee would like to draw the ministry's attention to a variety of items, provide general comments and request clarification on specific sections of the act. As such, we request that the following comments be given due consideration by the standing committee on social development and the Ministry of Health. Please note that the use of the term "legislation" in our response is intended to apply to the text of Bill 173 and the regulations which are to be added.

My presentation today will only touch on some of the comments that have been made by the long-term care planning committee. The remainder have been submitted to you.

The long-term care planning committee generally supports the purposes of the act outlined in part I. With regard to clause 1(g), the committee would recommend that this clause be reworded to strengthen the province's commitment to community-based decision making, and to

support the involvement of local volunteers in the provision of long-term care services. It's recommended that the enabling word "encourage" be replaced by "ensure" or "require," thus entrenching the essential role of local community involvement. Clause 1(g) would therefore read: "to ensure" or "require local committee involvement in planning, coordinating, integrating, managing and delivering community services."

With respect to the definitions contained in subsection 2(1), the committee would recommend that the definition of "person" include the individual consuming community services, their lawful designate and their care givers. The current definition does not reference the individual receiving services. The committee would suggest that the individual receiving services be called a consumer.

The committee would recommend that the legislation indicate the primary consumer groups who are to be served by the MSA system. The act is clear on the definition of community services to be provided by the MSA system; however, direction with regard to the principle consumer groups to receive these services is absent. The absence of a definition of the principle consumer groups implies that all individuals who meet the eligibility criteria to be defined in regulations will be the consumers of MSA services. If this is the intention of the legislation, it should be clearly stated.

Subsection 2(3) provides a definition of community services. Given that the current long-term care system employs homemakers, health care aides, attendant care workers and is currently preparing a curriculum for a personal support worker, the committee would caution that the services which can be provided by the worker not be limited to the services included under similarly titled community services described in the act. To avoid instances where multiple workers must enter the home to provide specific services, workers should be able to provide a wide range of services. For example, homemakers or personal support workers should not be limited to providing services classified as homemaking services or personal support services.

Part III, bill of rights: The committee supports the inclusion of the bill of rights for consumers in the legislation. The committee would recommend the inclusion of an appeals mechanism, as per part IX of the act, to include violations of the elements of the bill of rights. Such an appeal mechanism is available with respect to service delivery decisions under section 32.

Part V, funding and approvals: Clause 6(g) indicates that the minister may make grants and contributions for consultations, research and evaluation with respect to community services. The planning committee believes that the ongoing examination of community services in the district is necessary.

As the timing for the implementation of the MSA system may not permit the completion of our comprehensive examination of the community services in our district prior to the identification of a preferred MSA structure, the ongoing examination of these issues will be required by joint initiative between the MSA system and the DHC.

Part VI, multiservice agencies: It's suggested that section 11 be modified to outline the role of the DHC

and the identification and recommendation of the preferred MSA system to the minister and the minister's commitment to designate MSAs in accordance with the recommendations of the DHC.

Subsection 14(1) deals with the provision of information by the MSA system. Our long-term care planning committee has identified the need for accurate, up-to-date, comparable information on long-term care services as essential to planning. The establishment of a province-wide information system for programs and services offered through MSAs will enhance long-range planning and will improve the accuracy and efficiency of the information and referral services of individual MSAs.

Subsection 20(3) refers to those persons able to participate in the development and revision of a plan of service. The care-giving role of family and friends is supported by the inclusion of care giver support services as a community service in the legislation. This clause recognizes the importance of involving the consumer and those lawfully authorized or designated to participate in the development and revision to plans of service.

The committee supports this participation but would suggest that the requirement to designate persons who are able to contribute to the plan of service not be too restrictive or rigorous so as to exclude input from the variety of individuals, family, friends and others who may be involved in supporting the individual.

Section 21 refers to the provision of services. The committee agrees that services must be provided in a timely fashion. The committee would suggest that the legislation establish a 24-hour period as a target for the time between the MSA's receipt of the phone call and the consumer receiving an assessment of service needs.

The redevelopment of the long-term care service system to achieve one-stop access may lead some members of the community to assume that services will be available as soon as they pick up the phone and contact the MSA system. However, the MSA system will need time to assess and prioritize needs and to arrange the delivery of services.

In urgent or crisis situations, the ability to respond immediately must be available. The definition of "timely fashion" should be dependent on the urgency of the individual situation. Legislation and/or regulations must be flexible enough to support the MSA system in its attempts to deal with crises or urgent situations.

Section 23 refers to the provision of written notices. To support consumer participation and understanding of the process, a written notice should be available in different languages and in formats suitable for those with visual impairments and low literacy levels, and should offer explanations and interpretations as are provided for in subsection 29(12) with respect to a person's plan of service.

Part IX, appeals: The committee would recommend a phased approach to the resolution of concerns involving the consumer, the service provider and a local appeal body. In all cases, every attempt should be made to resolve the concern directly between the consumer and the provider before going to an appeal body.

To reduce the potential number of incidents where a formal appeal would be necessary, and the associated costs and delays in client services, the committee would recommend that the legislation provide for the opportunity and authority for a local, perhaps independent, appeal body to form and operate.

Part XI, general: Section 56 of the act deals with the regulations. The regulations will contain important direction for the new long-term care system. As such, any and all opportunities for consultation with DHCs, service providers, consumers, their care givers and other individuals should be undertaken prior to the finalization of the regulations to the act.

With regard to subsection 56(30), the committee would request that when requiring certain qualifications on the part of service providers, the ability of the consumer to identify the preferred care giver not be sacrificed. This ability is particularly important when the consumer requires assistance with personal needs. The MSA should have the ability, like the current attendant care program, to identify and train an individual suggested by the consumer to provide personal care services. The best care giver for the consumer may or may not be the one who has received training through a formal program. Educational supports to provide training to individuals identified by the consumer should be available if needed.

The regulations should permit the maintenance of existing relationships and the continuance of partnerships between consumers and their care givers. Comfort levels between care givers and consumers take time to develop and must be supported in the new system. In-home workers provide companionship and friendship, as well as direct service.

In closing, I'd like to thank the standing committee on behalf of Alan and the members of the long-term care planning committee for the opportunity to provide our comments and suggestions. As was stated, the planning committee supports the general direction outlined in the legislation. The committee asks that its concerns and suggestions be given due consideration by the standing committee and the Ministry of Health.

The DHC and the committee welcome any questions with regard to the material submitted today.

0940

**The Chair:** Thank you for a very full brief. I note for the record the additional document you have left with us with further explanation.

**Mrs Barbara Sullivan (Halton Centre):** Welcome to the committee. We have had some concerns in our party with respect to the inclusion of the DHCs within this particular bill in that most of the attention throughout the province—and we've had extraordinary attention directed to Bill 173—has been with respect to the multiservice agencies, how they will disrupt or affect existing agencies in communities, and very little response, frankly, to the district health council, what that role should be.

We really feel there should have been a separate piece of legislation concerning district health councils, their mandates, the kinds of resources that would be available to them, the expectations of them and the accountability,

not only to the minister in terms of their mandates but to the community in terms of their mandates.

I was quite pleased to see that you've raised some of those issues, although I note that you didn't raise the issue of resources. I think that's one of the issues that certainly has been a matter of some concern for DHCs right around the province.

You also mention the necessity to cross boundaries frequently from one DHC to another with respect to planning and service access, and I think that's something that's important.

One of the things I'm unclear about from your presentation is whether your district health council and your long-term care planning committee of the DHC accepts the model for the multiservice agency that the government has put forward, which is a provincially mandated model that will be a monopoly provider of services as well as the place for one-stop access; how far you are in your planning; and where you see your own agencies such as the VON and home care which now exist fitting in. Are you looking and is the community looking for ultimately some flexibility in the design of the model, or are you willing to accept this new bureaucracy?

**Ms Jeanne Thomas:** I'd just like to respond to that question, Barbara. Currently, the long-term care planning committee has representatives from the VON, the home care, all of our key stakeholders at our planning table. Over the course of the past nine months, we've been developing as a community-conscious, decision-making planning body to work within the provincial policy direction to design a multiservice agency model or system for our district.

As far as the planning committee's support of the provincial direction, yes, they do support the principles of a multiservice agency: improving access to service, availability of information on services, improving efficiencies, making the system very accountable. Yes, they do support that.

When you mention a provincially identified model for an MSA, I should say that the planning committee doesn't interpret the policy documents to be promoting one model for service delivery. Certainly we would request flexibility, and we have assumed that we do have the flexibility to design an MSA system that meets the needs of the district as a whole.

**Mrs Sullivan:** I suppose my concern is that the planning documents in fact would have indicated that there was that flexibility, but this Bill 173 takes that flexibility away and allows only one model, which is the central multiservice agency which must not only provide the access but also deliver all of the services. In other words, your VONs and your Saint Elizabeths and so on will not exist under this model.

**Ms Thomas:** I guess we haven't come to that conclusion, that existing agencies will no longer exist in their current form. Certainly we've accepted that we are going to amalgamate and have an amalgamated system for long-term care service delivery. Certainly not one MSA has been decided yet for our district, but we do support the bringing together of existing agencies.

Currently there are a number of initiatives going on in the district exploring possible interpretations of how we might bring existing agencies together yet still maintain their identities and also the services that they provide in the community and the strengths of their services in the community, whether that's a local presence or a volunteer involvement.

Certainly we keep interpreting the policy to be flexible. From the start we've understood, though, that it is a one-stop access system and that the province's direction and its answer to how to achieve one-stop access was by creating multiservice agencies.

**Mrs Sullivan:** I just want to tell you that we will be putting forward amendments to reflect the kind of activity that you're taking. This bill does not allow that activity.

**The Chair:** I'm afraid I'm going to have to intervene there; we're over our time. I know we could spend most of the morning reviewing a number of questions, but may I again thank you very much for the work that you put into the presentation this morning; we really appreciate it.

#### NIGHTINGALE NURSING REGISTRY LTD

**The Chair:** I then call on the representatives from the Nightingale Nursing Registry, if they would come forward, please. Welcome to the committee. Please go ahead with your presentation.

**Ms Sally Mark:** Thank you. I'm a little nervous, so try and bear with me. I'm here today to—

**The Chair:** Don't be nervous. We get up in the morning the same way as everybody else does.

**Mr Jim Wilson (Simcoe West):** Don't worry. With this legislation the whole province is shaking.

**Ms Mark:** I'm here today to put a personal slant on how this legislation affects us as individuals.

First, I'd like to thank the committee for giving us the opportunity to make a presentation on Bill 173 affecting long-term care in this province. I'd like to introduce myself. My name is Sally Mark. I'm the director of finance for Nightingale Nursing Registry. I'm here today with my mother, Maureen Mark, president and director of operations. Together we wholly own and operate Nightingale Nursing Registry Ltd.

I'd like to tell you a little bit about how Nightingale evolved and then I'd like to outline how Nightingale is affected by Bill 173. Finally, I'd like to make some recommendations for the committee's consideration.

First, the evolution of Nightingale. In 1981, my father retired from the transportation industry with 30 years' service and we relocated to the Peterborough area. My mother, Maureen, a qualified registered nursing assistant, looked for work. After some time, Maureen began working for a health care registry on a sporadic basis. Her employer then defaulted on payment of over \$1,000 in wages and court action was necessary.

My father, concerned about the financial security of his family in the future, encouraged Maureen to open her own health care registry, to be a small business owner. "After all," he said, "many women had become successful entrepreneurs." Thus, in February 1985, Nightingale Nursing Registry was established.

The first two years of operation were a struggle, as experienced by many new businesses. Certain that the future would hold an increased volume of business, they decided to take out a second mortgage on their home in the amount of \$30,000 to finance future operations.

Late in 1986, the company saw its big opportunity. Local administrators were actually inviting private agencies to make proposals to become the service providers of a new provincially funded program, home care. Peterborough county was also chosen as a test site to run a parallel pilot program, integrated home care.

Nightingale's proposals to provide health services under these new programs were accepted immediately. The contract was signed with local administrators and Nightingale's revenues increased dramatically. Everyone felt that the hard work and difficult financial struggles had finally paid off. In 1988 the company incorporated. In early 1991 my father passed away and I joined the company hoping to carry forward and build on the financial security he had built for his family.

In the fall of 1991, long-term care reform began. Soon the government's not-for-profit preference policy was clearly stated. Even though 50% of the services in Peterborough county were provided by private agencies, the government maintained that only 10% of these services should be provided by the private sector. This news was devastating, but the biggest shock of all was that the government was going to expropriate our business without compensation for the time, energy and money that our family contributed and the sacrifices that we made. The same government that invited us to participate in the industry was now forcing us to close our doors for ever.

Nightingale provides quality care where and when it is needed. Nightingale employs 120 home support workers and nurses and thus we are the second-largest employer in the village of Lakefield. We service approximately 300 clients, totalling more than 5,000 hours per month in both rural and urban settings. Some of our service is provided on weekends, holidays and evenings when no other agency is able to or desires to provide this service. We deliver quality care seven days a week, 24 hours a day.

#### 0950

We realize we are part of a highly regulated industry. Local home care program administrators set a fixed price for the services that we provide. A minimum wage for home support workers is also regulated. This means that both our revenue and wages, our principal expense, are controlled. Still, we managed to operate economically, without year-end deficits. After all, no one was going to help us sustain a loss, unlike our not-for-profit counterparts.

How does Bill 173 affect Nightingale? Some 90% of our revenue is generated from publicly funded home-making and nursing. I want to emphasize that—90% of our revenue is from the government home care program. Of the remaining 10% of private business, only 5% of those clients absolutely have no connection with home care. In other words, 95% of our private business results from the extension of home care services that we currently provide. What do these numbers mean?

If the private sector is limited to a maximum of 20%, which means 10% for Nightingale, because it's split between two private agencies in the Peterborough area, Nightingale will not be able to retain the critical mass necessary to survive.

If the government goes ahead with Bill 173 as drafted, Nightingale will become non-existent. Some 120 field workers and 7 administrative staff will lose their jobs. What is the justification for such a policy decision? These workers will draw UIC and other social assistance, costing the province a great deal of money in benefit claims. Has the government done a cost study to determine the underlying ticket price of creating an MSA and revamping the system?

The government, with this policy, seems to be promoting unemployment at a time when job creation seems to be a strong party agenda. Will the government guarantee that all of Nightingale's laid-off employees will be hired elsewhere when Nightingale's doors are forced to be closed?

I leave you with one final thought. As you know, small business drives the economy, creating employment and national wealth. Is bankruptcy the message that the government wants to give to the entrepreneurs of Ontario? Does the government believe that this degree of control exercised over small business will attract domestic and foreign investment for our province in the future?

We'd like to make a couple of recommendations. Nightingale recommends that section 13 of Bill 173 be amended to give administrators of the MSA the power to purchase unlimited quantities of service on a contractual basis from any service provider. It is, of course, reasonable to expect that these service providers will meet an explicit set of standards at a reasonable price. Nightingale believes that local autonomy is crucial in the delivery of services in highly diversified communities.

Nightingale recommends that the committee consider keeping the positive aspects of the current in-home health care system such as competition, consumer choice and local autonomy when creating new legislation to reform long-term care in this province.

I thank you for listening and we will now attempt to answer any of your questions.

**Mr Jim Wilson:** Thank you, Ms Mark and Mrs Mark, for what indeed is a thoughtful presentation and one that I know comes from the heart. I can't explain to you as Ontario PC Health critic why in the world this government wants to put you out of business. We've been fighting this since the 10% rule came in.

For what it's worth, the sympathy of my colleagues and I go out to you, your family and your over 120 employees.

**Ms Mark:** Thank you.

**Mr Jim Wilson:** It makes no sense. It defies common sense. The government itself, during the hearings on Bill 101, the first piece of long-term care legislation last year and again this year during these hearings, can provide no justification whatsoever, no cost-benefit analysis, nothing tangible to explain their simply ideological preference.

There's some hope. Yesterday we actually had a union,

the third-largest union in the home care industry, come forward and tell the government they were crazy, that there was no justification, that this hurts both the private sector and the not-for-profit sector and, unlike last year's hearings where the not-for-profit sector was essentially silent about the 10% rule, this year both sectors are continually hitting the government over the head in presentation after presentation after presentation, because the bottom line is that it's going to hurt consumers. I just want to ask you that.

First of all, I assure you that we'll be moving amendments to delete any reference to this. The policy of my party has always been to have a balance in the health care system between the private providers and the not-for-profit or public sector providers, and we will maintain that policy as we always did. We didn't start this. The previous government started into this sort of social engineering.

With that, I want to ask you, the people you actually serve, your over 120 employees, how are they going to feel when—I assume they've built up a number of trusting relations over the years with your people. Do they know what's coming down the pipeline and that the people currently providing services to them in all likelihood will not be employed in the new system or by the MSA? You also have to remember the government's made a promise publicly to displaced hospital workers, unionized, that they will get the first jobs in the MSAs. How do real people feel about this?

**Ms Mark:** First of all, a lot of our clients are unaware of the legislation that's going on. We've attempted on several occasions to communicate with them the significance of the policies that are taking place. Of course, there's continuity of service. We have several of our homemakers who have been with us for five or six years, going to the same client every Monday, Wednesday, Friday, and of course they feel that if they lose their trusted worker, their companion they've built this relationship with over a number of years, obviously they feel they won't be getting the quality of care that they got in the past.

ASSOCIATION OF ONTARIO PHYSICIANS  
AND DENTISTS IN PUBLIC SERVICE,  
KINGSTON BRANCH

**The Chair:** I invite the representative from the Association of Ontario Physicians and Dentists in Public Service, Kingston Branch. Good morning and welcome to the committee.

**Dr Jane Baldock:** My name is Jane Baldock and I'm a psychiatrist working at the Kingston Psychiatric Hospital. I have with me Dr Yousery Nashed, the director of the psychogeriatric inpatient unit at the hospital, who will join me in answering any questions you might have after this presentation.

I'm here today on behalf of the Kingston Branch of the Association of Ontario Physicians and Dentists in Public Service. As you've heard in previous presentations, the association was formed in 1974 and we have a membership of 400 full- and part-time salaried psychiatrists, general practitioners and dentists. Our members work in Ontario's 10 provincial psychiatric hospitals and nine

regional centres for the developmentally challenged.

We work with a group of the most vulnerable people in society today, people with chronic mental illness, schizophrenia, manic depression, dementia, illnesses that so far are only controllable, rarely curable and not preventable. Many of these people live to be 65, 70, even 80 years or more. Every day the staff at our hospitals grapple with the long-term care issues for these patients, yet the severely mentally ill are not recognized in Bill 173.

**1000**

This is our greatest concern about this Bill 173. Where are the provisions for the young adults and adults in midlife who also require lifelong care due to their mental illness? This bill as it now reads ignores the existence of a core group of severely psychiatrically disabled patients who can never adequately remain in the community without periodic support from the psychiatric hospital system. Both the community-based programs and the psychiatric hospitals have an important role to play in the long-term care of the severely mentally ill. This bill seems not to recognize the complementary needs of three very necessary systems, home, community, hospital, when it comes to those with chronic mental illness.

Here in Kingston we've been very lucky because we've been working towards that balance. The Metcalf clinic where I work is an outpatient program based at Kingston Psychiatric Hospital. Metcalf is a front-line clinic that's been operating for 16 years, and I've been there for just over five. Clinic staff were multidisciplinary. We have psychiatrists, community nurses, a psychologist, a social worker and an occupational therapist, and we offered a broad range of adult psychiatric services on a walk-in and referral basis. We had more than 800 patients. Some we saw several times a week; others only every few months.

This sounds like just the kind of community psychiatric outpatient program we've all been working towards. But because of funding cutbacks, since the beginning of July, the Metcalf clinic is closed to new referrals and the number of patients we see now number just over 300.

Where do the new patients with severe mental illness end up now? Probably in Kingston Psychiatric Hospital where further funding cutbacks will see \$6 million cut from the budget over the next 18 months. That's probably about 50 beds which would've been available to up to 250 patients over the year. With cutbacks, we won't be able to accommodate these patients now or in the future.

Who are these people we currently deal with every day in the psychiatric hospital system? Let me give you a couple of examples.

One of our patients is a 56-year-old man who has had a relapsing and remitting schizophrenic illness for more than 30 years. He lives in a town outside Kingston. Since being diagnosed, he's required four long-term admissions—that's more than six months—for stabilization and treatment of his illness. Recently, he was readmitted at the request of the police on a form 1. As you know, that's a three-day assessment period allowed under law for someone who risks his or her own safety or that of the community.

He was brought to us because of his disruptive behaviour. He had set a fire to a boarding house. He was assessed and treated by a multidisciplinary team that included a psychiatrist, nurses, social worker, psychologist and occupational therapist on the ward. Within three months, he was ready to be discharged. However, discharge planning organized by his social worker revealed that officials in the town refused to accept this man's placement back into their community, his own community.

How does this bill, or how will mental health reform deal with the plight of such a person who is unable to return to his community because it is not able to cope with the effects of his severe mental illness. In a few years, he'll be elderly. How will Bill 173 look after him then?

Another example is a patient at the clinic. This example shows the complexity of the issues of both mental health and long-term care. This patient is in her 50s and has schizophrenia. She's lived with her elderly mother for the last 10 years. She's well maintained on medication and monthly outpatient visits. Her mother has taken in lodgers over the years to help with the upkeep of the house she and her mother live in. Increasingly, over the last few months, this patient has become agitated because her mother is beginning to become very paranoid about the lodgers, paranoid to the point that the mother thinks the home is being vandalized and she wants to take legal action. This patient knows this is not true, but her mother is growing increasingly irritable and critical of her because she won't deal with the perceived problem by starting legal action.

In her sessions with us, we've been able to determine that what may be happening is that the mother is showing the first signs of dementia or Alzheimer's. The mother needs assessment at least by trained professionals in geriatric mental illness. For this one example we may be facing two different but very needy people who require long-term care in the near future. Where are these complex mental health and long-term care issues integrated in this Bill 173? We can't see it. The attitude seems to be: "Somebody somewhere will deal with you. We don't know who or where, but don't worry." Unfortunately, these people do worry.

Two of the three psychiatrists recently retired. We didn't know who was going to pick up the patient load, so the hospital told the patients in a letter: "Don't worry. We'll assign someone soon, once we know the schedule." Then these same patients heard that because of cutbacks, the clinic was going to be closed. They became very upset. They'd lost their primary counsellors to retirement; now they were losing their clinic. It's become so bad that some non-clinical staff have asked for training in counselling skills because many of their patients are so agitated about their caring environment being changed.

There's one other point I'd really like to make. With all the uncertainty surrounding the future of the psychiatric hospitals and the whole health care system, the very people who are the care givers are themselves affected.

Let me give you an example of this. As you know, the government recently has introduced a system by which

people who spend more than 90 days in a psychiatric hospital will have to start paying up to \$40 a day for room and board. In order to determine who can pay and who can't, someone in the psychiatric hospital system will have to carry out a means test. It will most likely fall to the social worker. Why should a highly trained social worker have to turn into a bureaucrat? So now we're going to turn the social worker into judge and helper in the same breath. That's wrong. Social workers are important for supportive inpatient and outpatient care. This new policy is turning them from a supportive role in the care of the severely mentally ill into a judgemental role. We're already understaffed with social workers. Why would any government want to turn this vitally necessary group of mental health care providers, who are one of the main links between the mentally ill and the community, into paper pushers?

Kingston is privileged to have both a geriatric psychiatry inpatient unit and a community outreach service. That means we can offer both kinds of care and treatment right in the community. But we're finding it's becoming increasingly difficult to return elderly with psychiatric problems to their nursing homes after treatment at the hospital. This is not surprising since nursing home staff do not have the expertise, and staff-to-resident ratios in nursing homes are less than those in geriatric wards of psychiatric hospitals. So we at the hospital can deal more appropriately with behaviour problems as a result of mental illness. However, as further beds are cut from the psychiatric hospitals, we wonder by whom and how these difficult-to-manage patients will be cared for. Where in Bill 173 are their needs recognized and dealt with?

Elderly mental health issues are a growing, not a diminishing, concern. Stats Canada 1991 figures state that 12% of the population are over 65. What seems to be overlooked in the long-term care bill is that not only will the aging population increase, but those suffering from dementia will increase exponentially. You've heard the figures before about the rates of dementia in the elderly: 8% for those 65 or over, 16% for those 75-plus, and as much as 35% for those 85 and over.

This long-term care bill doesn't even recognize that there exists an elderly population who have severe psychiatric illnesses, particularly Alzheimer's, which is a deteriorating, lifelong illness with no chance of recovery or improvement. Kingston is particularly concerned about these statistics because we have the second-largest percentage of people over 65, after Victoria. So long-term care provisions are of prime importance to this local community.

1010

You've heard the presentations from our association in Hamilton, Thunder Bay, London, St Thomas, Toronto and now Kingston. We hope that we've presented you with an understanding of some of the local mental health concerns of Bill 173. We also hope we've been able to show you that there are many common concerns with Bill 173 that affect all of us on the front line of treating and working with the severely mentally ill.

In closing, I'd like to remind you why I came here today. I came here to talk to you about people who often

can't speak for themselves, people who are going to be affected, very much so, by the bill that you are deliberating. All I can do is ask you to consider their needs and their plight when you deal with the task ahead.

Thank you for your attention. I would welcome any questions you might have for myself or Dr Nashed beside me.

**Mr Tony Martin (Sault Ste Marie):** Thank you for coming before us again and painting a picture that I think is what challenges this government to take on some of the tasks that we have put in front of ourselves and you for some answer, some response, some plan to try to deal with certainly the area of long-term care and the demand that will be put on that system as we look into the future. I think you painted that very nicely, the number of people particularly in this area, and the fact that we have to work collaboratively in this is going to be really important.

You mentioned the need for the home community and the hospital to be working in tandem or together cooperatively in front of this, and I certainly can't disagree with you. I think that's why this government has finally put some wheels on some notions that have been floating around for about 10 years now about how long-term care should be delivered in this province, and trying to put a framework around that so that it can happen.

You're aware as well that we're in the process of carrying out a mental health review that will be really important and hopefully, if we all work together, fit into the context of long-term care so that the pieces fit and one will follow the other. It's been certainly my experience in life before politics that we're not going to get a handle on this very difficult problem of how we deal with folks with mental health difficulties unless everybody is working together.

Our expectation is that we will put in place the framework, which is Bill 173, and that the community, through the long-term care committees, district health councils, will work with us in a reasonable, committed, intelligent fashion to use the scarce resources we have available to us at this particular time in our history as a government to put in place the best that's possible.

I guess my question to you in front of all of that, recognizing, as you've painted for us, the challenge that's there, is, are you participating at the local level in the long-term care planning process, and are you participating in the mental health review? How are you finding that participation? Is there opportunity for you to bring the very specific questions and issues that you've raised here today to those tables?

**Dr Baldock:** For myself particularly, I have not been asked, and no one in our association has been asked, to take part in the Long-Term Care Act development. I'm aware of committees in the DHC, which is very much struggling with this task, and I'm aware of a social worker in our psychogeriatric unit who asked to be allowed to sit on the committee. She had to present herself; she had to push herself in to be heard in the committee on the Long-Term Care Act.

On the mental health reform, of course our associ-

ation—because I'm secretary of our association—has been instrumental in beginning to have our voices heard around the issues of the severely mentally ill and the need to have at least a base number of beds still within the confines of an institution because of the needs in the extremes of this illness. But I think our major concern, even though integration may be verbalized, is that the pace that the Long-Term Care Act is going through is contrary to the pace at which mental health reform is taking place. I believe that once the act is in place in Parliament, if it is proclaimed, it will be very difficult to alter it or integrate it. There are some very specific issues in the Long-Term Care Act which will not allow a flexible approach with mental health reform to take place, and that's one of our concerns.

**Mr Martin:** I'm not sure how much time we have here this morning, but certainly the question of pace I think is important. I don't understand, to be honest with you, and maybe it's because I'm not involved personally in the mental health review process. I know that this piece has been on the table for about 10 years now and people are telling us it's time to get it on, to get it done, so that we can build on it and, as with everything else, improve it as we go. I guess my hope is that the mental health piece will fit into that. I haven't been shown yet specifically where that will or cannot happen. Perhaps you could comment on that for me.

**Dr Baldock:** I don't see that mental health, as I said before, is even considered in the Long-Term Care Act, and it is not. So it seems to me there are two isolates developing, perhaps in tandem, but there's no bridges between the two of them at the moment.

As you're aware, our association gave you a copy of the Mental Health/Long-Term Care Interface Working Group yesterday. I think the areas which are still deficient in the Long-Term Care Act are fully written up in that working document, and these people are linked with the DHCs.

**The Chair:** As you noted, we have had other representatives, so I think as we have gone along, we have come to a better understanding of these particular issues. Again, I apologize that we can't continue the questioning. We could go on for most of the morning, but we do appreciate your coming before the committee today.

PETERBOROUGH COUNTY-CITY

DISTRICT HEALTH UNIT;

HALIBURTON, KAWARTHA, PINE RIDGE

DISTRICT HEALTH UNIT

**The Chair:** I next call upon the representatives from the Peterborough County-City District Health Unit together with the Haliburton, Kawartha, Pine Ridge District Health Unit. I want to thank both of you for coming today and also for making a joint presentation.

**Ms Debra Cooper Burger:** Good morning, ladies and gentlemen of the committee. My name is Debra Cooper Burger and I'm a supervisor of coordination with the Peterborough County-City Health Unit, definitely the home care program in particular. I'm representing Dr Garry Humphreys, our medical officer of health, who is quite disappointed that he wasn't able to be here today to present directly to you. I've provided you with copies of

the brief representing the position of the Peterborough County-City Health Unit regarding Bill 173. It's not my intent to read the brief; however, I would like to comment and elaborate on certain points.

Before I begin, I'd like to tell you a little bit about myself. I'm a registered nurse and I've spent the first 14 years of my career in hospital settings. The last six years have been spent with the home care program, four years as a home care coordinator—also known as a case manager—and the last two years as a supervisor of coordination. I'm also the past provincial president of the Ontario Nurses' Association, which, many of you can appreciate, is the largest union representing registered nurses in Ontario. It's on the basis of my professional and labour relations background that I can speak to you today from both of these perspectives. I have been on the front lines of health delivery in this province, and now as a supervisor I am coaching and supporting other frontline workers in their efforts to provide quality care.

I can tell you that our health unit, our program and our staff welcome and support legislative changes that enable us to be more creative, more flexible in meeting our client needs. In fact, we have advocated and agitated for many of these changes for many years. At the same time, we're puzzled and somewhat defensive with aspects of Bill 173.

I represent a health unit that has done an excellent job of serving over 2,000 home care clients on a daily basis. As I'm sure you are aware, the home care client can be a newborn infant or the most senior of senior citizens, and we serve both the continuum of age groups and also acuity of care. We have done this in the most integrated, accessible and responsive ways that we could, despite prescriptive and rigid ministerial criteria. We have been cost-effective and efficient. We have demonstrated our abilities and held true to our responsibility for meeting client and community needs. I know this to be true because the health unit administration has facilitated many smooth transitions. We have been able to respond quickly to changing needs by implementing chronic care, school health support and integrated homemaking services, all during a decade of rapid increase in demand for our services.

As I mentioned, we were able to smoothly integrate the homemaking services program into our operation. We were one of the first programs to offer the integrated homemaking services. Our experience has provided us with a recent example that I'd like to share with you.

In collaboration with our homemaking agencies—and I might point out that Nightingale Nursing Registry that just presented to you is one of those agencies—we have been very successful in matching our clients on the integrated homemaker program with the right amount of service. As a result, we have achieved a savings in homemaking hours and we are now able to increase the number of clients that we serve. This has not happened overnight and it has come from the experience that we have as a program.

Matching the right service, in the right amount, with the right client are objectives of service planning and coordination. We provide service planning and coordin-

ation within a case management model. Our coordination staff are skilled in holistic assessment, resource management and multidisciplinary service care planning. Our health unit believes that case management is a professional service that objectively identifies necessary services and remains unbiased when evaluating service and changing needs.

Bill 173 ensures that people who apply to an MSA for service will be assessed and their eligibility determined, but it fails to ensure that this will be carried out by trained, skilled and experienced professionals.

Bill 173 further ensures the right of appeal. We believe this underscores the need for the sound assessments and sound decision-making skills demonstrated in professional case management practice. We encourage you to include case management in the list of professional services identified in this bill.

In our brief, we state that we have a proven record and that we provide a wide range of community-based services in a caring, accountable and fiscally responsible manner. We work hard to listen to and respond to what our clients need. Our home care program has provided an on-call service long before quick response was ever fashionable in this province.

We have implemented initiatives in palliative care, intravenous therapy and complex care, and our clients recognize these efforts. We receive numerous handwritten thank-you notes and cards from our clients. Our clients or their families often express their gratitude for our services in newspaper acknowledgements, and some even make financial donations, even though we're not a charitable organization and we can't provide them with a tax benefit.

We recently did a home care client satisfaction survey. We had a 40% rate of return on that survey, which I'm sure you can appreciate is a very good response for surveys. Our clients told us, and I can quote: "Great services," "Keep up the good work," "Could not wish for better," "Don't think it can be improved," and "The service I received was absolutely first-class." Our case management service was rated as excellent. Ladies and gentlemen, these are real consumers and these are real comments based on their personal experiences and their perceptions of the service we delivered to them.

The success of our program is directly attributed to an administration that has fostered a client- and community-centred approach not only in the home care program but in all of the programs under the umbrella of the board of health.

In summary, our health unit not only supports the purposes of the act as outlined in Bill 173, but we have made and we will continue to make them a practical reality. We encourage the committee to build on our strengths and to allow us the equal partnership in our communities that we have worked hard for and that in fact we deserve.

**Dr Alex Hukowich:** I'm Alex Hukowich. I'm the medical officer of health for the Haliburton, Kawartha, Pine Ridge District Health Unit and I too have to express my regrets on behalf of my vice-chair, Bill Wensley, who

has spoken to this committee in the past on the issue of long-term care. He was not able to be here today. I've left a copy of the health unit's brief, a large part of which has some very specific comments and questions relating to various parts of the act, and I don't intend to read that. I've got a couple of more serious concerns that I'd like to express.

Clearly, the board of health, as in the past, has indicated its support of the intent behind all of the steps that have come so far in terms of trying to improve long-term care services, make them more accessible to the public, make them better coordinated and make them more efficient, and in trying to improve the quality of service to people who require long-term care. However, my board and I do not believe that the plans, as outlined in Bill 173, particularly in relation to the creation of new agencies or a forced amalgamation of service-providing agencies, will accomplish those ends.

We believe that the ideals of coordination, improved access, are going to be highly dependent upon cooperation and coordination and that legislation does not create that. I think there's been reference to this legislation providing a framework. I would suggest that it will provide a straitjacket. It does not have the flexibility to lead towards improved services. In fact, as I've indicated in the brief, it really has created a potential fault line for a lot of disputes and difficulty in getting groups together to provide improved services.

We believe that this legislation is overcontrolling, and I have tried to get some explanation from the long-term care office as to the rationale and the reasoning behind the wording in various parts of this legislation and have not been able to get an answer. I had some preliminary discussions. I was told that the person had to speak to the lawyer who was involved in the drafting, that they would get back to me and they have not. So I'm at a loss to understand what parts of this have some kind of legitimate rationale in terms of the actual wording and what parts are purely ideologically driven by the desire to create new agencies.

The one thing that really concerns me, however: I wonder whether my board, myself and all of us have been wasting our time. I'm not sure whether you're aware of this document that was issued the date of August 22 on behalf of a Doug Jackson, office of the special adviser on MSA implementation. I have copies of this document. I only received a copy of this yesterday, but when I read this document, all of this, all of what's in Bill 173, seems to me to be a foregone conclusion. This document deals specifically—and I do have copies of this document—with governance of multiservice agencies.

It seems to me, as I say, that I'm just wasting my time talking to you individuals here. I hope that's not the case, but this seems to lay it all out. It's going to be the way it's in Bill 173. It has to be this way.

The thing that I find particularly ironic in this document, because it is something that I do firmly believe, is stated here under the accountability of the MSA board, "The board is accountable to the MSA's voting membership and ultimately to the community it serves." I would say that it's more important that the board be accountable

to the community not ultimately but directly.

The other part of this document that I find particularly amusing is that it says: "Elected individuals bring to the board their special knowledge and experience. Their role is to serve the best interests of consumers in the community." I believe that. I believe that election provides a direct way of individuals being accountable to the public they serve.

This document basically says that if you're elected from a small, select group of members out of your community, you are somehow more accountable than if you are elected by the entire community at large. I fail to understand how that can possibly be. As I say, I've got copies of this document if you have not been made aware of this, but it really seems to preclude any of this kind of discussion as to how this bill can be changed, amended to provide some flexibility in terms of how services are provided.

1030

As I say, I believe this will provide a straitjacket. This will not lead to the kinds of things that need to be done to improve at a practical level services in the community. I would say that just because you pass a law doesn't mean that certain things happen, and the absence of a law doesn't keep those things from happening.

I guess the prime example that I've just been able to find is, of course, there is very little in the way of legislation relating to district health councils, yet they were created, they have expanded across the province, they exist and they function even without legislation. On the other hand, I believe that under the Ministry of Health Act there is the requirement that, "There shall be a senior advisory body to the minister...known...as the Ontario Council of Health," and I'm not sure that even exists any more. So, clearly, the fact that you can put it down on a piece of paper, pass a law, will not make it so.

I believe that you can implement pilot projects across this province that should have been done some five and 10 years ago. You can see how they function; you can see how they operate. You don't need the act, as it's currently drafted, in order to do that, and then you can take from that the things that work and improve on those rather than putting us all into the kind of straitjacket that this legislation will produce.

**The Chair:** I've asked the clerk and we have circulated that document, but there are some members here today who may not have it, so that would be useful.

**Mrs Sullivan:** I can't tell you how much I agree with your presentation. I'm pleased you have pointed out the implementation document, which came to our attention just earlier this week and which we received. We too share your concern that the implementation materials which are being prescribed are in fact being distributed and insisted upon before the legislation is passed, before there has been the public discussion of the issues, when in fact—the clerk could give me the precise numbers, but I think we've had well over 200, possibly even closer to 300 presentations and I can only count two presentations before our committee that support this legislation.

**Interjection:** Three.

**Mrs Sullivan:** I'm told three. In most cases, where there is support for the principles of the legislation, what we see are recommendations for substantial amendment to the bill that would provide the flexibility for structural change and would certainly allow, by example, boards of health of municipalities to not be considered the last place for the MSA but there with other approved agencies.

I'm also interested in the point you have made in your brief which speaks about, on the one hand, the ministry requiring accountability within the community. But as you point out, the minister can approve agencies, premises, multiservice agencies and can intervene by way of controlling membership in organizations, removing directors, replacing directors, appointing program supervisors—I should say that is within the ministry—and taking over agency operations. No other legislation, such as the Public Hospitals Act, the Health Protection and Promotion Act and so on, have those kinds of powers that are allocated to the minister.

Do you want to talk about that for a minute, what that means for accountability at the community level?

**Dr Hukowich:** As I said, I believe this legislation is overcontrolling. I'm not a lawyer. I can't speak to the need for it to be drafted in this particular way. I do know that in looking at other pieces of legislation, it's nowhere near that kind of empowering to the minister.

If the intent is really to make the communities somehow accountable and have their structures within the community for the accountability, then I don't see the need for having the minister have so much power, given that there are already other means—clearly, there are means of financial control. Clearly, the government always, in the end, has that level of authority. They don't provide the funds; you can't provide the service. They provide you direction by way of policy and you have to abide by that.

I can't see the need for the minister to be able to control at so many different levels, all the way from deciding who the members may be within an agency—those are the ones who then elect the board of directors under this scheme—to replacing those individuals. I've asked people at the long-term care office: "What's the need for having both a piece that says you approve the premises as well as a piece that says you approve the agency? Are you really going to be in a position where you're going to approve an agency and no premises, or premises and no agency?"

It seems very strange to me, but I have not been able to speak to anyone, although I've tried, to find out whether there is some legal rationale for this. Clearly, I'm not a lawyer. Maybe there is some legitimate need for that, but I haven't heard any argument. I haven't heard anybody present any kind of information that says this is required.

**The Chair:** The parliamentary assistant would like to comment on a couple of the issues that you've raised.

**Mr Paul Wessinger (Simcoe Centre):** Yes, just some of the issues raised. First of all, with respect to the issue concerning this degree of control doesn't exist elsewhere,

I think I should point out that the legislation sets out a framework for community accountability, and without the legislation there is no framework for community accountability. There is absolutely the total control at the provincial level. Secondly, with respect to the public hospitals, there are similar provisions with respect to control and with respect to investigators and with respect to taking over with respect to the public hospitals area as well. So there is a parallel situation with the hospital situation.

**Dr Hukowich:** Again, I don't want to start interpreting law and I don't know whether the committee has had the opportunity or will have the opportunity of meeting with the legal drafters and reviewing other kinds of legislation, whether it is similar or different. There are powers of control over public hospitals and there are powers of takeover relating to boards of health as well, but they are quite different, in my view, from the level and the degree of control indicated in this document, in this bill.

**The Chair:** I want to thank you both for coming before the committee this morning and for the various points you've raised. We appreciate it.

#### KINGSTON, FRONTENAC AND LENNOX AND ADDINGTON HEALTH UNIT

**The Chair:** I call on the representatives from the Kingston, Frontenac and Lennox and Addington Health Unit. Welcome to the committee this morning.

**Mr Alex Lampropoulos:** Thank you for coming to our city. My name is Alex Lampropoulos, the chairman of the board of health for Kingston, Frontenac and Lennox and Addington. I have Dot Broeders, a member of the board who is appointed by Queen's Park, and Dr David Mowat, the medical officer of health and chief executive officer of our corporation.

First of all, we're not against the bill, period. I want to make that clear right from the beginning. Bill 173 is a matter of tremendous importance to the residents of this district as well as to the board of health and its more than 200 employees. I know you will consider carefully the written brief which we have provided. We could say much more about the bill but we have concentrated on one issue only, subsection 11(3), which requires that "the minister...consider the suitability of all other approved agencies in the...area" prior to designating a board of health as an MSA. You know how I feel? That we're at the bottom of the barrel, and that's what makes me very uncomfortable.

I want to very briefly summarize some of the points in our submission and I might help you to save time in going through the submission yourselves later on.

Why was this subsection 11(3) included in the bill? The three local members of the provincial Parliament, all from the governing party, had assured us that there was no reason why boards of health should not be considered. The only written explanation we have from the ministry is that it is a—listen to this—position of the government "designed to ensure that the composition of the board meets the" above-noted "criteria to be considered by the minister." It is the composition of the board, and we'll deal with that in a minute.

This does not make any sense to me and the reasons why will follow. The bill says that all potential MSAs are to be reviewed to see if they meet the criteria. So why are the boards of health singled out or excluded, if I may say? If we don't meet the criteria, then it's obvious we're not going to be chosen.

#### 1040

Hospital boards can be considered. Listen, are they much more representative of the community than the boards of health? I don't think this is a valid reason. I think it is pure discrimination. Subsection 11(3) is very discriminatory towards the health units of Ontario.

We are also denied the opportunity to change our composition in order to have the diversity of membership which the bill is looking for. I agree, we agree with the diversity. It has to come from all walks of life, and membership should be truly representing all segments of our society.

At present, this board has 10 members who are members of the councils of this area. They are reeves, they are mayors, they are councillors and they are elected by their own citizens, whom they represent, every three years. There are three more members appointed by Queen's Park, and listen to this: Since they're appointed, then we find it ironic that the minister comes back with subsection 11(3) and now tries to disqualify them. They're not suitable. The composition of boards of health can be changed and solve the problem. I'll outline briefly three ways to do so:

(a) Municipal councils do not have to appoint councillors. They can appoint citizens' representatives and that could be done if it is asked for by you.

(b) Without changing the Health Protection and Promotion Act, the minister can increase the number of provincially appointed representatives up to almost half of the members of the board, and this can be done tomorrow.

(c) The simple deletion of section 8 of the Health Protection and Promotion Act would give the minister complete freedom to change the composition of the board of health by regulation, the so-called "ministerial discretion."

I have a parallel here. Children's aid societies which, like public health, receive municipal and provincial funding are governed by a board combining municipality appointments and directly elected members. Boards of health can do the same to be like the children's aid societies. We also wonder why, if boards of health are so obviously unsuitable for long-term care—that's what subsection 11(3) says—they are good enough for public health. Is public health less important, to be entrusted to the boards of health and not the elderly at home?

There is a perception out there that boards of health are not corporations. We can change that perception by promoting it, by explaining it. That is not true. The act states that every board of health is a corporation without share capital.

So what is the reason, then? To be frank with you, I see no reason for boards of health to be excluded from the process of developing MSAs.

I want to make it abundantly clear that we're not

asking this committee today to say that the board of health should be the MSA. No, we're not here for that, but only that the district health council, on behalf of all the residents of this area, is entitled to consider all of the options. We want to be considered along with the other boards. We are very proud of our record and we'd like to be considered according to our record.

I have two areas to deal with. On cost-efficiency—this is our record; these are the facts—we have a network of branch offices, an extensive administrative structure already in place, and we're very proud of that. We are the only administration in long-term care locally which is familiar with a unionized environment.

Effectiveness, the facts again, I will list them to you:

(a) Twenty-five years' experience in building the program right from small beginnings to its present state, and we serve daily 2,100 patients.

(b) Cooperation with hospitals: We have pilot projects in the cancer centre and obstetrics; a study on reducing length of stay in the hospitals—very important to save money; patient satisfaction surveys etc.

(c) Constant improvements to service: Introduction of home intravenous therapy, dialysis, ventilation etc.

(d) Ability to cooperate with public health services in providing wellness programs. We already have in place the care giver support programs suggested by the ministry. It is here.

(e) Full capability and experience in marketing campaign.

(f) Volunteers and a volunteer coordinator. The volunteers, ladies and gentlemen, in our community are the backbone of the community, offering their services. We attract the best and the hardworking people are with us.

(g) Teaching health unit, the first to involve home care. A critical, research-based approach to practice, emphasizing innovation, efficiency and quality.

(h) Research and education: A field training for all kinds of health professionals.

We are one of the few agencies in the province of Ontario to operate both a home care program and a placement coordination service.

In summary, by not allowing the board of health to sponsor the MSA, you create the maximum amount of dislocation and expense in bringing a new MSA into existence. What we want, ladies and gentlemen, and what we know the public wants is as much funding as possible to go into services. The way to do that is to—and I'm not trying to teach you here, I'm not trying to make you listen and go and do it, but these are the facts.

**Mr Noble Villeneuve (S-D-G & East Grenville):** Don't be shy.

**Mr Lampropoulos:** No, I'm not. The way to do that is to maximize the administrative efficiency. People call it downsizing, people call it restructuring. We call it administrative efficiency and we believe that this is what we can do, the health unit of this area.

My last thing: We do not speak for all boards of health in Ontario, only for this one. I was a listener on August 23 when the president of the ALOHA and the past presi-

dent made a presentation to you, Mr Chairman, and to your committee. They asked me to do my bit here, and that's why I'm here. But if only one health unit in this province of Ontario were to be the ideal candidate to become the local MSA, then your committee has an obligation to strike out subsection 11(3) of Bill 173.

**1050**

**Mr Jim Wilson:** Thank you for your presentation. I think you made an excellent presentation and I agree with all the points, except for your first point, and that is that you're in favour of the bill. Other than that, we're on the same wavelength and we will be moving an amendment to delete subsection 11(3).

**Mr Lampropoulos:** I'm pleased to hear that.

**Mr Jim Wilson:** You make a very persuasive argument. I certainly can assure you that during third reading debate we will use some of what you've said today in debate among I and my colleagues in the House. I guess, though, what you have to remember is that after three and a half years of being Health critic and four years of sitting in opposition to the NDP, one has to always look at what is the hidden agenda on any piece of legislation they concoct.

It has been suggested, since they can't seem to come up with a rational argument for why they're discriminating against municipalities and boards of health with respect to who can be an MSA, that perhaps because of the overprescriptiveness of the bill—just using the example of Simcoe county where I'm from, certainly I can tell you that because municipalities are made up of legitimately elected local officials, and boards of health for the most part also have those representatives on them, they probably wouldn't put up with much of the directive that's coming. Therefore, one of the suggestions is that the NDP needs to start all over again with some new people in an MSA, in a new agency, so they can ram through their social engineering.

I can tell you, my municipal councils don't even adhere to their welfare rules that they changed a few years ago. We still have welfare inspectors in the county of Simcoe and we keep hiring them all the time. They just keep saying to the government: "Sue us. We don't care. You're wrong." So we don't follow a lot of their directives now locally because we still have common sense in our locally elected officials. That's one theory.

The second one that's been approached is, we know unionization will increase under this. The Christian labour council yesterday said yes, indeed, the speed of unionization in our sector, and we also know that over half of the community-social service sector right now, those delivering services, are not unionized in the province.

If you combine this bill with last year's labour bill, Bill 40, this is one-stop unionization. You get a new MSA, and you know once there's one union in under the same roof, it's very easy to put a petition before the labour relations board and you have one-stop unionization. So that's the other thing that you can come up with as an explanation of why the bill's written this way.

Do you want to comment on those theories?

**Mr Lampropoulos:** In all fairness to the governing

party, we have the support of the three local MPPs, as I said, and we have the support of others who are sitting around the table who are members of the governing party, and the bottom line is that they're good listeners and they prove it by coming to this area. You are coming here to listen to the grass roots, and we appreciate it very much. I hope what you said about 11(3), that it will be deleted—I hope you will agree and I hope we have a unanimous decision for that to be recommended to the government for the third reading.

**Mr Jim Wilson:** Well, let's just find out. Because we're in week three, we're down to the wire. I'll ask the parliamentary assistant: Is that an amendment the government is willing to accept, and then we don't have to go through this, hearing presentation after presentation?

**The Chair:** I'll turn that question to the parliamentary assistant. He also wanted to comment on that aspect.

**Mr Wessenger:** I think you'll have to wait for clause-by-clause, Mr Wilson. But if we deal, first of all, with 11(3), it should be made clear that 11(3) does not prevent a board of health or a municipality from becoming an MSA. I mean, there's a local planning process. It certainly states a preference, but it doesn't state a prohibition, and there's quite a difference between a preference and a prohibition.

I might just add that Mr Wilson had indicated there has been no reason expressed, but I think we have to realize, and I'd appreciate your comments on this, that a board of health does have many responsibilities besides, for instance, the whole area of long-term care.

Certainly one of the bases, I would suggest, for preferring a single-purpose, non-profit corporation is the fact that the board would be solely responsible for the delivery and supervising of the whole long-term care aspect. It wouldn't have other responsibilities, as a municipality does, which has very many others. Even a public health unit has certain other responsibilities. I suggest that is one of the underlying principles with respect to the preference for the single-purpose, non-profit corporation. I certainly appreciate your comments on that aspect.

**Mr Lampropoulos:** That begs an answer from me and the gentleman to my left. First, that's wrong, what you are telling me. If it's true what you are telling me, then why is it there? Delete it; take it out. If it spells it out that will be considered at the end, that is almost as well excluded. If what you are telling me is true, just delete it; take it out. We don't need it.

**Mr Wessenger:** Could I just ask what you're asking, then? Instead of having that particular clause, you're requesting that criteria be established, rather than sort of dealing with the question of—

**Mr Lampropoulos:** No. The DHCs will decide, not a centralized government trying to govern everything from Queen's Park. I have the medical officer of health who wants to elaborate on this.

**Mr David Mowat:** If I could just comment, Mr Wessenger, I'm having some difficulty following the government's position on this.

It was in this very hotel a few months ago that the

minister herself told me she accepted the argument we had made about an earlier version of the policy that MSAs should be set up under completely separate new bodies. Our argument was that if we did that, we would have all the dislocation and expense of setting up a separate governance and a separate administration. We were told by our government party MPPs and by the minister that they accepted that argument and that in the legislation the MSAs could be run by existing bodies. I heard you two minutes ago say that we can't do that because whatever body you choose, whether it's a board of health or any other existing body, the fact that it's already in existence means that it has other duties.

What is the government's position? You're going to have a body that looks only after long-term care, in which case by definition it's a new body that didn't exist before, or you're going to have an existing body, which by definition must be looking after something other than long-term care. What's the position?

**Mr Wessenger:** Well, the position is that existing agencies can become MSAs. That's clear; that's very clear. But there are other existing agencies that—

**Mr Mowat:** But you just told me you can't look after long-term care and something else. What it seems is that that only applies to boards of health. I get the reason.

**Mr Wessenger:** Respectfully, I would suggest that I said it is a preference aspect.

**The Chair:** I'm sorry; I think the points have been made very clearly and I'm afraid we are going to have to move on. I want to thank you for coming before the committee and for the material which you have left with us today.

**Mr Lampropoulos:** I just provided you with this. It was in our local paper. It doesn't look good to me. It doesn't look good to the government of Ontario. Please delete the clause.

## 1100

### PROVIDENCE CONTINUING CARE CENTRE

**The Chair:** I call upon the representatives from the Providence Continuing Care Centre. Thank you very much for coming to our sessions today.

**Mr David Bonham:** We're delighted to be here to participate in these discussions, which are important to all of us. I'd like to first of all introduce myself. My name is David Bonham. I'm the chairperson of the board of Providence Continuing Care Centre. With me I have—and you'll have no trouble distinguishing them—Sister Sheila Langton, the administrator of Providence Manor and also vice-president, east, of the larger body, the Providence Health System, which operates right across Canada or at least in many of the provinces; then the other individual here, Guy Legros, who is the president and CEO of the centre. We're the people who are here on behalf of the centre.

My task is going to be quite brief. I'm going to make a few comments—in a descriptive sense, without too much history, so don't worry about that—about the centre, and then I'll ask Sister Sheila and Guy to carry the discussion further.

You can see from our material that we have really just

three points to make, and these will come later. Obviously, in a bill of this magnitude there are many, many things that could be said and should be said, but we've confined ourselves to those three points. But maybe just to put this in a setting, I should comment about the centre itself. It has a long history in Kingston and we, I don't mind saying, I'm happy to say, are very proud of the centre. I think it's made a great contribution over the years to this community in many, many ways. It has two branches. One of them, of course, is St Mary's of the Lake Hospital, and the other is Providence Manor. They are operated as one entity now in terms of the governance.

With regard to the bill itself, it touches more on the Providence Manor side, so I'm going to comment primarily from that aspect. That of course does not mean to say that we aren't equally concerned about St Mary's of the Lake Hospital.

We've endeavoured over the years, and I think the track record is very clear, to provide high-quality care and service to this community in a responsible way, in an open way, in keeping with the standards of society and the religious order, the Sisters of Providence of St Vincent de Paul, that has sponsored these institutions from the beginning. We offer a very broad project, and I'm happy also to say that we've done this, I think throughout, staying within our budget. That is true today, although, as you know, that's becoming more and more difficult as time goes on.

With regard to the hospital—I'll just touch on this; you'll see it in the notes—we have a major continuing care aspect to it which covers 169 beds. Then we have the geriatric program with 18 beds and the rehab program with 36 beds. That's the situation as it now exists and will continue in the future.

With regard to Providence Manor, we provide long-term care to residents who have chronic diseases and disabilities and we serve a very wide community. We do this, and I want to emphasize this, both within the institution and by a whole variety of outreach programs. It's primarily the outreach programs that relate to this bill: not exclusively, but that is where the emphasis lies. I'd like to draw your attention particularly to two such programs, and I might just say in introducing them that we are of course somewhat concerned whenever changes occur that could affect these programs. There's a lot of work and history and devotion and commitment and now heritage that relates to these programs.

The first one I'll mention is the Hildegarde Day Centre, a very significant program which began about 20 years ago, at that time in collaboration with the government, and ever since. It offers a seniors' day program for people who are not residents within the institution. They come and participate and it's a very positive thing for many of these people who don't have any other outlets in their lives. On a regular basis, we serve about 118 persons. So it's quite a significant program. These people come, physically not all every day. On a daily basis about 26 people come, and they stay there and participate in a very wide variety of activities, and we have a lengthy waiting list. So that is a very important, I think, initiative

within this community.

I'd like to also mention the attendant care outreach program. This isn't quite so old. I think it goes back about 10 years. But again it's something that is growing, and it's becoming much more relevant, I think, to our society as changes occur. It enables people with disabilities to remain in their communities, and we provide services to them. The idea here, of course, is to take the services to the people so that they don't have to become institutionalized, but this requires a tremendous support group and skilled attendants and others. At the present time we have about 63 clients in this program. And this will interest you: The average commitment in hours per week is about 21. So it's a very significant responsibility that we have to serve these people in their own environments through the attendant care outreach program.

These are the two particular programs that would be impacted, if that's a verb, by this bill primarily, and therefore I think that's where our attention should lie. I will just say, as chair of the board, that we are concerned with any change that could affect—and it's not just a selfish concern. We feel these programs have developed very vigorously, in a very positive and effective way, and we feel they are not only important to us but they are important to this community and to this province. Therefore, I don't mind saying—I feel I should say—that we do have concerns whenever changes are on the horizon that could affect them and therefore we come from that point of view, not in an attitude of obstructionism but of legitimate concern, because we feel we've developed these and we want to continue to carry them forward with the particular stamp and flavour of our institution and the religious order behind it that has I think contributed so immensely over the years.

Those are my comments, and I'm now going to ask Guy Legros, the CEO of the centre, to continue.

**Mr Guy Legros:** Good morning. First of all, I'd like to say that we do support the basic principles of the bill, and that is the equity of services, increased, simplified access to the services and also the reform of long-term health care. We agree that changes are required.

However, we suggest that the potential impact of changes should be investigated before they are implemented. This will require very serious and extensive analysis before implementation, and we see no evidence that impact cost studies, for instance, will be initiated prior to passing this bill. What is the cost, for instance, of setting up MSAs across the province, and with that, there would be an ongoing cost as well.

Here I'd like to quote a couple of paragraphs from the compendium. The first one is:

"The Long-Term Care Act, 1994, creates a legislative framework for community-based long-term care and support services for elderly persons, adults with physical disabilities and persons who require health services at home."

Secondly, "The act provides for a new way to plan, manage and deliver community services consistent with government's strategic directions for reforming community-based long-term care and support services."

It's very clear from these statements that the emphasis is only on community-based services.

We would like to suggest that chronic and rehab hospitals play a significant part in the continuum of long-term care services. The chronic care implementation task force has reviewed the role statement provided in the Chronic Care Role Study and the following role statement has been finalized, and I think it's very important that you really listen to this, these words that are included in that role statement:

"Chronic care hospitals and units will serve clients with complex needs. They will function in the continuum of health care, along with other client-focused partners: acute care, long-term care, mental health and community services...."

"These hospital services may be provided in ambulatory, inpatient and community settings. Within the chronic care system, people of all ages will be served."

1110

It should be noted that hospital services are not the last resort. They do provide assessment and treatment allowing people to return to the community, both inpatients and outpatients. It is often very necessary for hospitals and homes for the aged to admit patients or residents due to the complexity of medical and personal needs and the limitations of home support.

Our centre does provide in the Kingston region institutional coverage for those requiring assessment, treatment and rehabilitation. For example, a young disabled person serviced by the attendant care outreach program at Providence Manor may require the professional therapeutic care of St Mary's of the Lake Hospital for a period of time and then return to the community. Another example would be the Alzheimer-diagnosed person living at home who may benefit from the respite care provided by the Hildegard Day Centre at Providence Manor.

Bill 173 deals with the issues of access, coordination and integration of essential community services. MSAs will provide "one-stop shopping," but consumers will not be aware that choices have to be made between the provision of health services and social services, as they will all come from the same spending envelope. Also, an individual's needs may have little to do with the level of care provided.

Under the current system, consumers have a choice in the services they receive and from whom. Under the new system, MSAs would absorb existing community services, such as the Red Cross and VON, and take away that choice. The elimination of freedom of choice will not likely improve services provided.

MSAs will become very powerful and centralized agencies, rigidly controlled by the provincial government. We can expect serious competition for scarce resources. For example, social services providers will be competing for health care dollars at a time when the home care program for acute health care needs is increasing due to shorter hospital stays. Will MSAs grow to become monopolies, that is, bigger and more expensive?

Many charitable organizations presently offer services to the community. One of the major ties to the commun-

ity is through our volunteer boards. Under Bill 173, these boards will be replaced by a large regional provincial bureaucracy directed by government appointees. It is likely that many volunteers currently available within our community would not identify with government-controlled agencies.

The commitment of our staff and volunteers to the philosophy and value system is not the product of, here quoting the bill, a "service name, logo or a service location," as suggested in the new legislation. It is the product of our heritage. Our board members and volunteers respond to the vision of providing patient/resident-focused holistic care, meeting physical, social, emotional and spiritual needs.

We are convinced that volunteers and their fund-raising activities are essential to cost-effective long-term care and to the development of new services in the present environment of constrained government funding. We suggest that it would be the role of agencies working under MSAs to maintain, support and coordinate their own volunteers consistent with their individual philosophy, values, mission and the founder's heritage.

As stakeholders in the system, we recommend that agencies could operate together more effectively under an MSA umbrella, rather than the single integrated board structure in the proposed legislation. We recommend that the MSA for this region use multiple providers which continue to retain their individual identity and mission. In other words, use the brokerage model whereby the MSA purchases the required services from a variety of existing agencies. This, by the way, is how the health unit in this region is now functioning efficiently and cost-effectively.

I think Sister Sheila will give you the conclusions that we have.

**Sister Sheila Langton:** Good morning. In bringing these remarks to a conclusion, these remarks that have been made on behalf of Providence Continuing Care Centre with regard to Bill 173, I begin by saying that the Sisters of Providence and their associates have been on the front lines of human services delivery in this province and in the Kingston area for more than a century. Inspired by their historic roots and traditions, and often in collaboration with government, they have been leaders in designing, expanding and improving programs.

We do not believe that this province will be better served by the destruction of community-based volunteer boards in favour of a large bureaucracy directed by a handful of government appointees, as proposed in the legislation. The enlarged health care bureaucracy will not attract the volunteers and the private donations that now augment the services provided by charitable community agencies.

The institutional system of care and the community-based system should not be isolated from one another. Together, they should offer a continuum of care that shares resources, standards and accountability.

As we acknowledged earlier, changes are required. However, we should be sure the changes will bring about improvements to the system before they are implemented.

It is good that we have the opportunity to make our

contribution to the process of long-term care reform, and we are appreciative of this.

We are asking our legislators to make significant modifications to Bill 173 to better respect the dignity of those we serve by recognizing their desire for a continuum of services that are based on personal, faith, cultural, social and linguistic preferences and to permit the continuance of voluntarism and community support.

Mr Legros is going to now refer to the summary of our three recommendations, which is on the first page of our submission.

**Mr Legros:** Thank you, Sister. There are three, and the first is recognition and support for continuum of care. We recommend that institutional services be considered as part of the continuum of MSA services. Institutional and community-based services must not be treated as mutually exclusive but should be recognized as complementary programs in the provision of long-term care.

Providence Manor operates a highly successful adult day program focusing on the needs of clients with dementia. The expertise necessary to maintain this program is located in the homes for the aged program, and we think the community should continue to have access to this expertise.

The second recommendation deals with the provision of consumer choice. We recommend that the new legislation not eliminate the freedom of choice. Under the current system, the public has a choice in the services they receive and from whom. The delivery of care should continue to be the responsibility of the well-established and high-quality service provider agencies which currently exist and operate under the brokerage model. Agencies could function under an MSA umbrella organization.

Our third recommendation deals with the retention of voluntarism and community support. We strongly recommend the continuance of existing community-based volunteer boards. The loss of volunteers will also significantly reduce the financial support which now augments the services provided by the charitable community agencies. Volunteers donate time and money because of the heritage, philosophy, mission and value-based holistic care. Our health care system needs volunteer commitment and dedication, and we recommend that we build on the existing strengths rather than destroy the level of voluntarism, which, by the way, is working very, very, very well.

I'm sure there will be questions.

1120

**Mr Paul R. Johnson (Prince Edward-Lennox-South Hastings):** As is probably evident, we members of the committee don't get a lot of time to ask questions or make comments. Maybe twice throughout the course of the day I'll have that opportunity, so I'm going to try and say as much as I can in this short period of time that I have.

With regard to all the presentations that have been made by agencies that are within my catchment area or that I'm within theirs, it's very good to hear them say that generally they're supportive of the bill. However, they have some specific concerns, and indeed we

recognize some of those concerns, and indeed, as was stated by previous presenters, the local government MPPs have taken these concerns consistently forward, and I think that was indicated.

**Mr Jim Wilson:** And, and, and.

**Mrs Sullivan:** And.

**The Chair:** Order.

**Mr Paul Johnson:** And I think it's—

*Interjections.*

**Mr Paul Johnson:** And as you can tell, all the members of the committee get along very well and we seldom interject when our colleagues are speaking.

But just with regard to your presentation specifically, I don't know whether MSAs were characterized fairly. That's the one, if it's at all negative, I wanted to make.

But with regard to your summary of recommendations, it's my understanding that what you're asking us to recognize and consider has already been done and been granted. I thought it would be important for me to make that statement now so that you could go away today, at least, satisfied that we have already taken your concerns into consideration and that things are better.

**Mr Legros:** Well, that's nice to hear that. We're pleased.

**Mr Jim Wilson:** It's not true.

**Mr Legros:** If it is, we're okay. So that's the other side of the coin.

**Mr Paul Johnson:** I don't have a question per se, and as I said, I don't get a lot of opportunity to make any comments, but other than what I've said, I think that concludes my remarks.

**Mr Wessenger:** Perhaps I should just clarify what has been stated. Certainly with respect to the recommendations, we do recognize and support the continuum of care and appreciate those comments, and also with respect to the matter of volunteerism and community support, and certainly with the matter of consumer choice, that is indicated in respect to the development of plan of service, the fact the consumer is involved.

One thing I would just like to clarify: I think it should be very clear that MSAs are not appointed boards. They are a volunteer board and non-profit corporation, hopefully a charitable corporation. I just thought that should be clearly put on the record.

**The Chair:** Any comment—

*Interjections.*

**The Chair:** Excuse me. Order, please. Would you like to comment on that, Mr Legros?

**Mr Legros:** I am not exactly sure of what the process will be for the formation or the composition of those boards.

**Mr Wessenger:** Perhaps I should indicate that obviously there will be differences as each local community establishes its own recommendation, because it's clear that it's laid down that it has to be a non-profit corporation; or it could be, for instance, a cooperative, or it could be a board of health or it could be a municipality. There are various choices set out.

**Mrs Sullivan:** It can't be Red Cross, though.

**Mr Wessenger:** It has to have a corporate structure, obviously, of some sort. But there's a great variety within that that can be developed. It's up to the district health council to sort of recommend what type of model, or maybe an existing organization. It's going to be the local planning process that determines what models come forward, and I can anticipate there will be various differences throughout the province which recognize the differences in the province in what is developed, just as there will be a differing timing schedule. Some communities will move ahead faster than others with respect to developing MSAs.

**The Chair:** I know we could continue with questions, but I'm afraid we have to move forward. Thank you again for coming before the committee this morning.

VICTORIAN ORDER OF NURSES:  
HASTINGS, NORTHUMBERLAND,  
PRINCE EDWARD BRANCH;  
EASTERN LAKE ONTARIO BRANCH;  
LANARK BRANCH;

BROCKVILLE, LEEDS AND GRENVILLE BRANCH

**The Chair:** I next call upon the representatives from a variety of Victorian Order of Nurses branches: the Hastings, Northumberland, Prince Edward branch; the Eastern Lake Ontario branch; the Lanark branch; and the Brockville, Leeds and Grenville branch.

The four VON groups that are before us, we had agreed with them that they would make a joint presentation. We don't have time for four presentations, but we have provided some extra time because they are coming together as one. If there is sufficient time, I will permit a question from each caucus.

**Ms Penny Smiley:** I have been elected as the spokesperson for the group, to actually read the presentation to you, but should there be questions, I may well be calling on my colleagues to assist with the answers.

**The Chair:** Congratulations on your election.

**Ms Smiley:** Thank you. As we are the last presentation before lunch, we'll try and respect your biological needs and be somewhat brief in our presentation. However, we have, as was already mentioned, submitted a lengthier written brief for your consideration.

My name is Penny Smiley. I am the president this year of the Eastern Lake Ontario branch of the Victorian Order of Nurses. I am, in my real life, I guess, employed in the education field as a labour relations adviser for the local school board. However, today I am here as a volunteer of the VON.

With me I have Ross Craig, from the Lanark board of the VON; Kathy Robertson, president of the branch in Brockville, Leeds and Grenville; Mary Lou Workman, president of Hastings, Northumberland, Prince Edward county branch, as well as a member of the executive of VON Ontario representing southeastern Ontario. Judy Roth is also from the Brockville, Leeds and Grenville branch and is also a member of the VON Ontario executive.

Also present today are many staff members of the various branches. From Hastings, Northumberland, Prince

Edward branch we have Mary Clarke, who is the assistant executive director. From Eastern Lake Ontario, which covers the Kingston, Frontenac, Lennox and Addington area, we have Ivan Ip, the executive director, as well as Deborah Pennell and Sheilaegh Nowlan, and from VON Ontario we have with us today Don Austin, who is the assistant provincial executive director.

These branches provide a multiplicity of services. They include visiting nursing; shift nursing; community foot care clinics; Alzheimer's programs, which includes respite care; Meals on Wheels; friendly visiting and palliative volunteer visiting; information and referral; telephone reassurance; income tax assistance; medical transportation; home maintenance; home help; occupational health; a grand friends program; assessments for the Department of Veterans Affairs, insurance companies and placement coordination; bereavement services; cyclical-assisted dialysis; mildly ill care services and student placements for colleges and universities.

We have 456 staff members and 454 volunteers among the four branches. At one time we had over 5,659 clients on our combined caseloads. We service a total population of about 538,000. Through the four VON branches which I represent, our communities benefit from 14,818 hours of volunteer service a year and about 371,062 community nursing visits. Thus as major providers of health and social services in this area over many years, we have watched with interest the progression of the redirection of long-term care and the development of this legislation.

The mission statement, objective and core values of VON are included in our written brief. The Victorian Order of Nurses is committed to providing leadership across Canada in the development of health and social policy, the delivery of innovative community-based nursing and other health care and support services based on the principles of primary health care.

We are actively involved in many ways in planning for the future of our community services.

#### 1130

In reviewing Bill 173, our boards found much to endorse. The idea of a single access to services is one which we have long recommended. We support the establishment of core services to meet the community's needs. The elimination of duplication in assessment, client choice and a client bill of rights are in keeping with the philosophy and objectives of VON as well. We know that well-organized and integrated services are essential in this uncertain economy.

The VON branches are dedicated to the provision of community-based, client-centred care. We caution, however, against unnecessary rigidity in designing systems to meet the long-term care needs of residents in our communities. We request that the act and any regulations to the act provide for and promote a partnership model for the MSA involving a federated board—that would be a board which has representatives from all the service providers which still are independent entities—and an integrated service delivery model.

We believe that current staff from community agencies should have equal access to jobs in the MSA, irrespective

of whether they are unionized or not. Otherwise, the severance cost to agencies would be prohibitive.

There are other areas in Bill 173 that seem unclear to us. The effect of a government funded and controlled MSA on volunteer service and on private donations, in memoriam donations in particular, is impossible to predict, yet these fund-raised dollars and donations of service represent an enormous economic contribution to the current system. We would hope that good planning might ensure that services to our communities are not lost because of the passing of this bill.

The branches on whose behalf I am speaking support the purposes of Bill 173 as cited by the minister. Our own programs have been expanded to provide comprehensive services at the home and in community settings. We support consistent eligibility criteria but question the intent of uniform rules and procedures.

We believe procedures need to be kept simple and practical. The purpose of assessing eligibility for a meal or a drive to a medical appointment may be significantly less involved than the initiation of a complex service plan for a palliative client dying at home.

We believe that communities, working with the DHCs, should be able to develop flexible models and to have local boards govern their multiservice agencies in ways that best meet the local needs.

Encouraging such local involvement and flexibility will promote the most efficient management of resources. VON itself is founded on the practice of local community boards planning, coordinating and overseeing the delivery of services in partnership with the community, clients, staff and other providers. This participation and commitment of voluntary boards has enabled us to provide excellence in health and social services throughout the 97 years of our history.

Looking at part II of the act, "Definitions and interpretive provisions," the branches support the inclusion of the services listed. We suggest that respite, palliative care and bereavement support be cited as additional, distinct components of community care. Our branches support the availability of mandatory province-wide services in keeping with consumer needs.

The bill of rights cited in the proposed act is incorporated in VON's philosophy of service and we are pleased to see this entrenched in Bill 173. We do not, however, see that this bill ensures the right of the consumer to choose a type of service, location or provider within the resources available. We would welcome some assurance that the advice of the community and its district health council will be taken by the minister in making final decisions regarding the best administrative models for the future.

Our branches recognize the need to control the escalating expenditure in health and social services and to allocate scarce resources carefully and wisely. Providing services at home by community-based agencies has been shown to be cost-effective. However, we have concerns that the legislation gives no guarantee of adequate funding for services to meet future consumer needs. The gradual shift from institutional to community care has

resulted in more acute and complex service requirements at home. Visits for treatment now take longer and are thus more expensive to deliver.

We believe that funding of community care should be determined by the actual needs of the population and not by historical or census data. The current cost structure is known, but the costs of the future are not. Populations over 65, epidemiological factors, population density and travel required are only a few of the factors to be considered in determining funding needs. We hope that community planning will progress at a rate that permits good research into all the economic factors, and planning based on accurate data and well-informed predictions.

Financial data on integrated models in other provinces, such as Quebec, could be made available to community planners, and a detailed cost analysis of various models could be completed before a request for proposals is made. In the absence of necessary financial planning data, a pilot should be considered to minimize the potential adverse effects.

As I have said, VON supports community partnerships in sponsoring the MSA. Alliances of current health and social service providers would ensure a one-stop access to the range of core services and to information and referral.

The governance boards of consumers and experienced providers created by this legislation would provide good accountability and increase the likelihood of success. Additionally, this structure avoids having another level of government, such as boards of health, as the sole sponsor of the MSA, when they may well have other priorities and thus might not have the time and comprehensive focus that an MSA deserves. Community partnership is preferred.

Because this volunteer involvement in governance of the MSA is so tightly tied with the agency identification, a partnership model of community agencies would be more likely to preserve the current volunteer involvement so necessary to the system's future.

In addition, any human resources planning done as part of the redirection of long-term care should consider, as a labour relations issue, the role of volunteers in service delivery within a fully integrated MSA.

Our boards believe that the preservation of jobs of experienced people working for all agencies within the current system is an important issue. Recognition of seniority rights of non-unionized and unionized workers within the system and of those in non-profit community agencies, as well as government-funded agencies, is paramount in preserving the expertise to operate the new system well.

Unless jobs are protected or unless a partnership model with a federated board is chosen by the community, severance costs for non-profit community agencies could be significant. Since any surplus in non-profit agencies is returned to service in the community, few organizations have any equity to pay severance.

If severing employees becomes unavoidable, the government, having brought on the situation with this legislation, should reimburse the agencies for these costs.

Offering current agency staff jobs in the MSA or promoting the federated model could avoid this unfortunate situation.

The four VON boards of directors have some concern that the term "MSA" is already in common usage and that it means little to less-informed consumers. Perhaps a more descriptive title, such as "county community service agency," could be considered.

In summary, the VON branches support the purpose and intent of Bill 173 and we propose, where community consensus exists for a partnership model for the MSA, that incentive transitional funding be allocated to allow for appropriate local implementation.

**Mr Dalton McGuinity (Ottawa South):** Thank you very much for your presentation. I want to touch on this aspect of volunteerism and the impact that Bill 173 is going to have on it.

The government members have assured us that they expect the volunteers who have developed a loyalty to individual organizations, each with their own characteristics, culture, uniforms, logos, mottos, special missions, will somehow be transferred to an MSA.

I think our life experience dictates that people in Ontario in 1994 perceive the government, or an extension of the government, as being at best neutral, at worst something negative. I think we're going to have a difficult problem attracting volunteers to work for your local MSA. That's my interpretation based on my life experience, and I think many people would agree with that.

1140

To pursue this a bit further, and I want you to comment on this, I got hold of the people who run the Canadian Centre for Philanthropy. They, as you might infer from the name, promote philanthropy throughout the country generally speaking, and volunteerism in particular. They told me that of all the registered charities, those two which attract the least numbers of volunteers are hospitals and universities. Interestingly enough, those registered charities which receive the greatest proportion of their funding from the government are hospitals and universities. So they are perceived to be extensions of the government, and "I'm not going to help the government because, surely to God, there are other people there with greater need than my government."

Would you care to comment on that?

**Ms Smiley:** Well, I'll start out commenting and then others may wish to give their own perspective on it.

One of the greatest concerns of VON Ontario and all the branches it represents, I believe, from the first draft paper that we saw on the MSA, was the effect on and potential decimation of the volunteer sector in Ontario as a result of this bill.

Certainly speaking from my own perspective as to why I volunteer, I volunteer for the VON because I believe in what it does and I believe in it as an organization. It certainly makes full use of its volunteers, both in terms of board members and in terms of those volunteers who provide direct service, such as the Meals on Wheels drivers, and I don't think that sense of belonging and that sense of contribution to a community not-for-profit

charitable agency will be there for many volunteers for an MSA. That would be perceived to be a branch of the government by many people in the community. That's my perception. I don't know if others would care to comment.

**The Chair:** Please go ahead.

**Ms Mary Lou Workman:** I'm speaking from the loyalist section of the province, and I guess I don't have to describe what that geographic area is, but I have had many people personally speak to me about their role as a volunteer and their disinterest in continuing the role and the service they're providing now as we move into the development of an MSA, because they perceive it as an extension of a government. Not only do we lose their time in that aspect, but we will also lose their funding. It's been made very clear to me in our area that that's their attitude.

**Ms Kathy Robertson:** I share that as well. In my area we have a very strong home support program, and it has been expressed by the volunteers who provide all the service in this home support program that they will not work for a government agency. We are encouraging them that we hope to maintain a lot of local autonomy, that we can keep this strong base in our small communities. I think you find in your rural communities that where you get a lot of support to your local people is through the volunteers. We do not want to lose this, and we're working very hard—we've had meetings together—to keep up our feeling of, you know, "Let's continue on; we do not want to lose this."

They do provide an awful lot, but there are areas like Meals on Wheels and providing service to people receiving medical service in other areas where they have to have transportation. That funding is still going to have to be available from the government. Volunteers cannot provide that alone and we hope that funding will remain and perhaps be enhanced.

**Mr Sean G. Conway (Renfrew North):** Your geographic area is where?

**Ms Robertson:** It's Brockville, Leeds, Grenville and Lanark as well. We've been meeting together.

**Mr McGuinity:** Just one final comment: It just seems to me that at any given time the government ought to be doing whatever it can to promote, nurture and encourage volunteerism, but particularly when we've hit the fiscal wall. We have no more money. It's all the more important that we do whatever we can to promote volunteerism, and my concern is that this bill is going to do the exact opposite.

**Mr Jim Wilson:** Thank you for your presentation. I may just say that in my area of the province Meals on Wheels is 100% volunteer, both in its delivery and administration. There is, of course, some government support in terms of financial dollars, but why this government would want to destroy that—and the people who are currently volunteering in that program are quite distraught over this legislation. They can't understand why they would want to be brought under an MSA at all.

I do want to talk for a moment, though, about the federated model that you put forward; at least, that's what

it's been called by many groups. I think that makes sense, and I think—and this is the question—was that not the original intent, an idea that really we were all talking about, I thought, for the last decade with respect to the reform of long-term care, that we would see a governance model that was, as you suggest, made up of representatives of existing agencies? I still for the life of me can't figure out where the government got the idea that the MSA should be a new agency plus it should have a monopoly on the delivery of services.

I attended many of the public consultation meetings that preceded the drafting of both Bill 101 and Bill 173, and I didn't hear an outcry from the public that they wanted a new agency, that they wanted to destroy the VON and the Red Cross and the Saint Elizabeth Visiting Nurses and many, many other agencies and that there should in the new model also be an 80-20 split that says you should also deliver the services. I just didn't hear that. I want to know—because the government says that we did hear that in its 75,000-person consultation; that this was the overwhelming consensus—is that true in eastern Ontario, were people crying out for the model, or did they think we were just going to get one phone number, a fairly simplified system with a somewhat federated governance model?

**Ms Smiley:** I guess I'll start. I can't speak for all of eastern Ontario on what they wanted; I can, however, speak for what VON wants in eastern Ontario. I think that when we, as the four branches represented here today, got together in July to try and look through the bill and plan out our presentation, it was a uniform feeling around the table that the federated model was definitely the preferred model for our general area. Certainly, for Kingston, Frontenac, Lennox and Addington, we've had the pleasure of speaking with all of our local MPPs to express this concern to them from our very local perspective as well.

We feel quite strongly for the preservation, as I've said, of volunteers and for the preservation of the service as it is provided, that you can do that by keeping the agencies, by having a federated model and yet looking to the main common goals of the bill, the reduction of duplication of service and all that kind of good stuff that the bill represents, and do that through a federated model without wiping the whole slate clean and starting over with something completely different.

**Mr Jim Wilson:** Perhaps what I'm trying to get to, though, is the basis for this model, and let's be clear: We're told time and time again that it came from the people of Ontario during the long-term care consultations. I'm just wondering if in this part of Ontario—because I'm assuming that you were part of those consultations, that you held forums in community halls two years ago. We're told even that the notes from those meetings indicate that this is the type of model the people of Ontario wanted. Yet in public hearings colleagues who have been around the Legislature longer than I can't remember a time when well over 95% of the presenters to this committee haven't told us this is not the model that they thought we were discussing when we were having consultations on long-term care.

So for the public record, and if we are to ask for changes with this legislation, we need to know, were the people of Ontario here crying out for this model or did they really have something else in mind?

**Ms Workman:** If I might just respond to that, VON has always promoted the type of model that we again bring forward in this presentation, as we did at the hearings. Many, many times at the hearings, both at our Ontario level and as it moved across the country, we raised the issue of the concerns that we again bring forward here and the concerns that you say. My personal reaction is that the bill has responded to a specific consumer group that was very successful in lobbying the government in the formation of the bill and does not reflect very well at all the provider aspect that we fed in as these other former hearings took place.

1150

**Ms Jenny Carter (Peterborough):** I must say it is frustrating just to get so few cracks at this, and I do thank you for allowing time for rather more questions. I certainly welcome your general support for the bill and the concern that we share for helping the consumer and the good work that you do.

We just touched on a whole raft of things. It was mentioned that we did have a very extensive consultation before this bill was drawn up. I believe the first suggestion that was put out by the government was much more bureaucratic than what we are in fact getting here. A major change that was made as a result of the consultations was to have multiservice organizations and very independent local functioning in this field.

We did something that governments haven't really done much before: We went right down to the grass roots; we consulted consumers, very large numbers of them, as well as stakeholders. It is a fact that the representations that we're getting to the committee are largely stakeholders. That is not to say anything against stakeholders, but I think we should remember that what we're all trying to do ultimately is to serve the consumer, and the consumers were consulted and listened to.

Also, I'd just like to point out that large amounts of extra money are flowing into the community level of long-term care. I believe it's going from \$550 million in 1991 to over \$1 billion in fiscal 1994-95. So we're not cutting back; we are expanding community services here, because we feel that's where people want the services to be and we want to keep them at home as long as possible.

You, like many other groups, have a particular concern with volunteers. I'd just like to put it to you that we are definitely hoping and expecting that volunteerism and fund-raising and so on will continue through into the new system. In fact, there's actually a series of forums cosponsored by the ministry, the Association of District Health Councils of Ontario and the United Way of Ontario that are examining volunteer recruitment, retention and fund-raising in the new system. Also of course the local planning is being done by volunteer boards, and we're not doing this overnight. There is a long transitional period so that the existing agencies and the volunteers can, as it were, come together in the new system.

Of course the VON itself is a very large organization, yet you do attract volunteers, as do hospitals, which are large organizations. I know both St Joseph's and Civic in Peterborough, which I represent, do have large and devoted bodies of volunteers. So I don't see that we are necessarily jeopardizing that, and we are working very positively to make sure that the volunteerism is not lost. I just wondered if you'd like to comment further on that.

**Ms Smiley:** I guess I'd like to pick up, to start out with, on one of the last things you said, that VON Ontario is a very large organization, and that's true. We are a very large organization in Ontario, composed, however, of very many small organizations. VON Ontario itself has some offices in downtown Toronto and a few staff; not very many staff. The staff and the people who are VON are at the local level, and we operate as four local boards. We have our own boards of directors, and we operate very much at the local level. We have different programs.

Our concern is really at the grass-roots level. So I don't want the committee to have the impression that we have some monolithic person in Toronto who dictates what we do for the rest of it. Our basis and the backbone of VON and the strength of VON is in the community and in people we serve in the community. I just want to make that point very clear.

I think that the volunteers who volunteer for VON volunteer for VON, eastern Lake Ontario, to serve the people of Kingston, Frontenac, Lennox and Addington, or they volunteer in Lanark to serve the people in Lanark, or Leeds and Grenville or Prince Edward, Hastings and Northumberland. I don't know that they necessarily identify with the provincial whole, but they identify with the local and with the VON and what it represents in their community and the services it provides. I think our concern is that that's where the volunteers come to us from and that's why we as volunteers work for the organization.

**Ms Carter:** I think that's what we're saying, that volunteers are serving their own communities, and they can continue to do that just as much under this new system as they have done before.

**Ms Workman:** The message we are attempting to get across is that the volunteer identifies with the agency that he or she chooses to respond to. We do not see that this will continue in this act. This act describes an agency that is developed at length, is an arm of the government. I can only say it over and over again that volunteers will not respond to that type of agency.

**Ms Carter:** But you see, it's not really an arm of the government; it's a local organization.

**Ms Workman:** We're talking past each other.

**Ms Carter:** We feel that we did respond to what the public wanted by making it less an arm of the government and much more a locally generated and governed organization. I think that's the point that we're having difficulty maybe in getting across.

**Ms Workman:** But the point is that the people in the communities are continuing to identify with the agencies that have been in their communities for years and years

and are really upset and concerned that these agencies will be redesigned, broken up, and they don't know whom they are to relate to. They want to continue to relate to the agency that they're comfortable with. Is that clearer?

**Ms Carter:** Well, I hope they would want to continue to relate to the people they're serving, which will be a certain group, whether it's people who need Meals on Wheels or people with arthritis or whatever. Those people will still be there.

**Ms Workman:** That's true, but it is the mission statement and the goals of that particular agency that also bring the volunteers forward.

**The Chair:** If I might at this point, I think the position is quite clear. At this stage, perhaps we all need a little long-term care in the form of lunch. May I thank you all for coming before the committee this morning.

*The committee recessed from 1157 to 1345.*

KINGSTON, FRONTENAC AND  
LENNOX AND ADDINGTON  
DISTRICT HEALTH COUNCIL

**The Acting Chair (Mr Dalton McGuinty):** Our first presenters this afternoon are presenting on behalf of the Kingston, Frontenac and Lennox and Addington District Health Council. I'd ask you to introduce yourselves, please, before beginning.

**Mrs Shirley Sedore:** I'm Shirley Sedore. I'm a consumer member of our district health council and the chairman of the long-term care committee. With me I have Judith Mackenzie who's the senior planner on staff, and Cheryl O'Connor who is the long-term care planner for our committee.

Our comments will be in three parts. First we will provide some background information about the Kingston, Frontenac and Lennox and Addington District Health Council. Second, we will make some comments about Bill 173 as it relates to planning issues for long-term care reform and, lastly, we will provide comments as the bill relates to changes in the Ministry of Health Act.

The Kingston, Frontenac and Lennox and Addington District Health Council was established in September 1981 with 16 members. We have had and continue to have some unique challenges in meeting our mandate to provide advice to the Minister of Health on health issues for our district. We also see these challenges as opportunities. The geographic area is long and narrow with the majority of the population residing close to the 401 corridor. The district population structure is relatively similar to that of the province, but within the district there are wide variations. The population in the southern part of the district tends to be younger, has a higher income level, has attained a higher level of formal education, has less unemployment, lives in urban communities and has a wide variety of services.

Residents in the north live in widely dispersed hamlets and rural areas where there are fewer services from both the comprehensive and the quantitative aspects and transportation is a major issue. Being from Flinton, I can safely say that there is a cultural difference, with northern people having a strong sense of independence as well as

interdependence. Every issue which council works on requires us to consider both the rural and the urban perspectives.

Some district initiatives which council spearheaded and believes have had a significant impact for district residents include the community health centre in north Kingston, the long-term care facility in Northbrook, the community mental health program in Lennox and Addington counties, the redesign of the eating disorder program at Kingston General Hospital and the design of the base hospital program at Hotel Dieu Hospital which included the services in adjacent districts. More recently we have been working on designing a community mental health service for Frontenac county and working with Hotel Dieu Hospital on the consolidation of acute hospital psychiatric services at that institution.

Many years ago council decided that if district resources were to be used by people outside our district, they should be involved in the planning for these resources. This requires council to work closely with adjacent districts and communities both from a provider and consumer perspective. The cost to council for this regional planning is greater intensity in the use of planning resources and greater complexity in decision-making and problem resolution.

Areas in which we have led regional planning include transfer and transportation issues among tertiary hospitals, community hospitals and long-term care institutions; diabetes education for prevention of complications; and activities to enhance the information exchange and problem resolution between the 11 hospitals in southeastern Ontario. Two ventures we are especially pleased with are the design of the regional geriatric assessment program which allocated resources to the two adjacent districts and the development of the renal dialysis strategy which made the development of a unit in Belleville a priority over the expansion of beds at Kingston General Hospital. People in Brockville who remain in their own community for geriatric assessment, and people in Belleville who go down the street for renal dialysis will echo how successful these ventures have been.

In relation to Bill 173 and long-term care reform, we would like to commend the government for this major step towards achieving consistency throughout the long-term care system and for making consumers, their care givers and the informal supports such important and visible entities.

### 1350

Part X of the bill refers to "revocation and takeover powers." We support this section but have concerns that district health councils, which are responsible for the initial and ongoing planning for this reform, may be left out of this issue. We are not suggesting this needs to be addressed in the bill but we do ask that in the development of regulations and/or policy that the requirements for involvement of the district health council in the redevelopment and planning for the service be specified. This kind of situation is a local community problem, and ultimately any resolution must come from the community.

Sections 25 and 26 refer to charges for certain services. In Ontario, we have had copayment in chronic care and

long-term care facilities, and it has now been extended to psychiatric hospitals. These copayments are for housing and food costs which do not apply when care is provided in the home, but there are many costs associated with providing care in the home which do not occur when care is provided in a facility. These include transportation, higher percentage of indirect care costs and higher costs for delivery of supplies, equipment and tests.

Having no charges for mandatory services is a laudable objective; but we question, given the economic environment and changing demographics, how sustainable this direction is. Now that the home care program has a definitive envelope, being able to meet the increased demand for services will have to come from internal efficiencies and the establishment of priorities or user fees for some services. Consumers in this district support the concept of a user fee for non-health services for those who have an ability to pay. We believe this is an issue which needs to be reconsidered and options explored.

We would like to commend the government for not using the word "consumer" in relation to the board composition on the multiservice agency, section 11. We believe clause 11(2)(a) clearly states that the board must reflect those who will be using the services.

In relation to section 62, changes to the Ministry of Health Act, we have a number of comments. First, we would like to commend the government for taking the significant step of specifying district health councils in legislation. We believe that over the past 20 years councils have demonstrated their ability to accept the responsibility for credible district planning and progressing towards regional planning. We believe being specified in legislation can significantly strengthen how councils discharge their responsibilities for health planning in the communities where members live and work. It would be helpful if the act or regulations specified that councils are responsible for community-based planning.

Subsection 62(1), clause 8.1(4)(c) makes reference to planning "for the development of a balanced and integrated" system. We would like to suggest that councils need to make plans for the development and implementation. This suggestion is based on the increasing body of evidence that effective change is achieved when plans are immediately followed by effective implementation.

We strongly support the enabling section in relation to aboriginal communities. We are pleased to see acknowledgement in subsection 62(1), subsection 8.1(6) that councils work best when they have the required information.

Clause 62(2)(d.1) refers to the establishment of regulations in relation to recruitment and selection of candidates for council and committees. We support the wishes of the government to specify in regulations, requirements governing the recruitment and selection of candidates for appointment to council.

Councils have two mechanisms for fulfilling their mandate: a committee structure and a small secretariat. If councils are to be responsible and flexible to planning needs as they arise, councils need to be able to adjust these mechanisms quickly in order to achieve their mandate. It is impossible for councils to sustain the same

level of intensity of planning on all issues, thus councils succeed by modifying their committee structure and re-allocating staff resources to address the priority areas. Most issues are planned and then go through a period of implementation before additional planning is required. Councils take this opportunity to work on other issues.

If a committee were to be designated in regulations, council would be required to establish and maintain activity in this area even though it was not a priority for that given year. We believe the government can achieve the same outcome by using policy to influence the recruitment and selection of committee members. This allows greater flexibility, which is greatly needed by councils. Long-term care and mental health may be the major issues today, but next year it could be diabetes, cancer, children's services or violence issues. We urge you to use government policy, not regulations, to influence council's committee structure and delete clause 62(2)(d.1).

In relation to the development of regulations, we look forward to district health councils, individually and collectively, working with the government in the development of any regulations which affect district health councils. We view this legislation as a sound framework upon which to continue to build a solid and successful partnership for health planning.

In closing, we hope our comments have been helpful and we thank you for listening. If you have any questions, we'll be glad to respond.

**Mr Jim Wilson:** Thank you for your presentation. I think you've raised a couple of points that had not been brought to our attention previously, and one of them is with respect to clause 62(2)(d.1). I think you make a very good point, because one of the concerns I and my colleagues express from time to time about district health councils is one that's echoed in many communities, and that is where government's consistently asking them to do a lot and resources are strained. I know that in the ones I've visited throughout the province.

For example, you mentioned dialysis services in this area and how successful you were. We were aware of that, actually, as a committee because when we studied dialysis services a few months ago certainly Belleville and your area were brought to our attention as examples of how one might proceed to address deficiencies throughout the province. But when we went to the government, it said: "Well, this has to go to the district health councils." A lot of money is being spent right now for DHCs.

The membership—to be quite frank, and not politically correct about it—of a number of the DHCs simply don't have the expertise to deal with the issues so my executive director in Simcoe county said, "You know, Jim, I'm going to spend eight months bringing them all up to speed to try and deal with the crisis in the province." As a result, we were supposed to have a report back from the central Ontario DHCs on the dialysis crisis in the province several months ago, and it's nowhere in sight. It's not their fault. They haven't got the resources and the expertise.

I want you to comment on that, because you say maybe recruitment should be based more on the task at

hand. At least that's my interpretation of what you're saying. To me, that might be a good, commonsense way to structure some of the committees of the district health councils.

Secondly, because I gather you're supporting this legislation—first of all, how many MSAs will be needed in the area you serve? Have you any idea what the cost is going to be, whether there is additional cost to the system and where that money might come from?

**Mrs Sedore:** We've more or less looked at the service sites, not the specific number of MSAs in our district. I think I'll defer to Judith, as far as that goes. But our point was not necessarily structuring the committees towards the work, although we do that. If you legislate that we must have a certain committee, then it's there for all time, and we may not need it for all time, which is why we would sooner have the committees established in policy rather than in regulation.

**Ms Judith Mackenzie:** The other point we're making is to distinguish between the requirement for appointing members of the council, which we see as quite a different process, as opposed to appointing—I don't know how many committees and task forces we would appoint in the course of the year, but they need to be able to be put together quickly to respond to tasks and then to be disbanded when their particular job is finished.

1400

**Mr Jim Wilson:** So you interpret, after the "and" in (d.1), that the government will pass regulations specifying particular committees. Is that the way you interpret that? Because the first part deals with candidates to the council—

**Ms Mackenzie:** Right.

**Mr Jim Wilson:** —and then the second part.

**Ms Mackenzie:** And also being very specific about the composition of the committees. We've been pretty rigorous in trying to involve consumers in our committees and I think we've done very well in that regard. There may be some other areas that will come up in a generalized piece of legislation that wouldn't be that appropriate to our particular district, because the province is not homogeneous. Every district is different from every other one and I think it would be very difficult to come up with a good piece of legislation that could be applied equally and made sense.

**Mr Jim Wilson:** Are you close to establishing costs at all for MSAs in this area?

**Ms Mackenzie:** I'll defer to Cheryl now. I'll give you the tough one, Cheryl.

**Mrs Cheryl O'Connor:** We're in the process of designing MSA models and consulting with the community. Part of what we will try to share with the community are some estimated costs, although this stage is an estimated cost; and it is not our understanding that there will be more money in our community funding envelope, so we recognize that whatever model we create, if it would cost more it will have to come from priorities or internal realignments in the system. Those are the dilemmas the community faces.

**Mr Jim Wilson:** I appreciate it.

**Mr Wessenger:** I was just wondering if I can clarify about the intention with respect to committees. The intention wasn't really to use the regulatory power to specify what committees a DHC would have. The purpose and intent of the regulatory power are to ensure that district health councils, for instance, when they do establish committees, like you do in your area, have consumer representation. So that's the purpose of the regulatory power, not to specify the committees that should be established.

**Mrs Sedore:** That would still be done in policy, would it not, or could be?

**Mr Wessenger:** Yes, it could be done in policy, but I think there have been probably some DHCs where there have been some difficulties with respect to their having the consumer representation on some of their subcommittees.

**Mr Jim Wilson:** Mr Chairman, if I may just put a point in here. One of the problems, and the group makes a very good point in terms of being too rigid here—take dialysis, Mr Wessenger, in our area. When someone's dying of renal failure, they don't really feel like sitting on a committee of the district health council. In structuring what we've gone through in our area locally, it required consumers. Well, we didn't quite get the consumers. We ended up getting friends of the consumers. So you want to be careful that you're not too prescriptive, I think. The consumers were a little ill.

**Mr Wessenger:** I think we would agree you need a broad definition, a reasonable definition of "consumer."

**Mr Jim Wilson:** It's broad when we're dealing with it here, but I'll tell you, when the directive goes down to the front line, it somehow doesn't have your interpretation on it.

#### ONTARIO COMMUNITY SUPPORT ASSOCIATION, AREAS 8 AND 9

**The Acting Chair:** Our next presenters are presenting on behalf of the Ontario Community Support Association, areas 8 and 9.

**Mrs Elizabeth Fulford:** Good afternoon, Mr Chairman, ladies and gentlemen. Thank you for coming to Kingston to hear the community response to Bill 173.

My name is Elizabeth Fulford, board member from area 8, and presenting with me today is Pat Dandelé, the chairperson of area 9. The areas we represent include Durham region, Northumberland, Peterborough, Victoria and Haliburton counties, and Prince Edward-Hastings, Frontenac, Lennox-Addington, Lanark and Leeds-Grenville counties. As you will see on the maps enclosed in the presentation package, we stretch from the border of Metropolitan Toronto to east of Cardinal and north to Algonquin Park.

Throughout the past month of hearings, I understand that you've become very familiar with the Ontario Community Support Association's mission, goals and objectives and the services provided by our member agencies' volunteers and staff. A copy of the services provided in our areas is included in the appendix. You have also been presented with the areas of the legislation that OCSA endorses and our key areas of concern.

Consequently, today we would like to look at Bill 173 from a local perspective, and the effect it will have on the clients we serve. The role of volunteers, fund-raising capacity and changes to the Public Vehicles Act are the areas we will be highlighting. A copy of our presentation has been provided for your review. We intend to make our comments reasonably brief to allow time for discussion or any questions you may have.

The community-based organizations which we represent support the intent of Bill 173 to simply improve client access to a continuum of community services and promote equitable access to those services. We've been waiting for more than 12 years to see a concrete attempt made to address the long-term care needs of our clients who live in the community.

The areas we represent present a rich diversity of urban and rural communities. Some are starting to meet the changing cultural needs of their areas while others are struggling to gain acceptance of the need for local community support services.

Some urban communities are stretching their resources to provide a range of services to meet the needs of frail seniors and adults with disabilities representing only 6% of the population, while others in rural areas are meeting the needs of the same group that represents 26% of the population.

Few urban centres have public transportation to serve all of their designated geographic areas. The majority of our rural areas do not have paratransit services such as Handi-Transit or indeed any public transportation at all. The residents rely greatly on escorted transportation provided by volunteers in private cars.

In area 8, a high percentage of home support and homemaking agencies has been developed on a regional or county-wide basis. The majority of home support services are provided by community-governed multi-service agencies which support clients through local grass-roots community involvement. We are concerned that assumptions are being made that there will be administrative cost savings as a result of the proposed amalgamations. In area 8, this will be impossible if service coordination volunteers must become paid staff.

**Mrs Pat Dandelé:** We are very pleased today to see a number of our area 8 and area 9 members in the audience, some of whom have already presented to the committee today and others who will be presenting later.

In area 9, there are 32 member agencies with approximately 6,000 volunteers spread throughout a primarily rural area. Many services have developed at the grass-roots level, with agencies such as my own responding to each community's individual and unique needs. Dedicated pools of volunteers from each community reinforce the commitment as a multitude of services are accessed through the local neighbourhood agency.

In both areas, the effectiveness of the work of our member agencies is due to the continuous collaboration and cooperation with other agencies, community groups and facilities.

It has long been accepted by community support agencies and funding bodies that local community

volunteers have a key role to play in the provision of direct client service and service coordination. One agency, for example, in area 8 has over 1,200 volunteers who last year provided 77,723 hours of direct client service and 23,407 hours of office assistance and committee work. Their contribution can never be transferred into staff hours.

The social support system which an individual has available to him or her has been well documented as a key determinant of health status. Community support agencies have mobilized volunteers and groups in our communities to show in a tangible way our care and concern for our neighbours in need and are dedicated to providing the necessary staff leadership to provide quality services.

We believe that a recognition of the role of volunteers must be entrenched in the legislation to assure clients and volunteers alike that we will indeed be providing the least intrusive, most cost-effective client-centred support services possible.

Volunteer management requires appropriate funding to provide for agency practices which ensure the successful recruitment, screening, training, scheduling, supervision, retention and recognition of community volunteers. Agencies which follow these practices continue to attract an increasing number of volunteers who participate in a meaningful way in their community.

We are concerned that the act stipulates in paragraph 56(1)30 a regulation "requiring that service providers have certain qualifications or meet certain requirements and prescribing the qualifications or requirements" without stipulating a companion regulation for volunteer management requirements.

Our agencies have skilled staff who must meet the case management, service coordination and service delivery needs of our clients. They also provide effective management of our volunteers. No other sector in the proposed reform requires such a broad range of responsibilities and skills from an individual staff person. Our clients and volunteers must be confident that Bill 173 will strengthen the staff support required to maintain and improve services.

1410

**Mrs Fulford:** There is concern that the bill may fail to reflect the unique funding that community support service agencies receive compared, for example, to the funding for home care programs and the agencies with which they contract service.

When home care contracts for professional and home-making services, the hourly rate includes administration and supervision costs. Therefore, when new dollars were allocated through quick-response proposals and the integrated homemaker program, the contracted agencies were able to provide service in a timely manner.

Over the past two years, those of OCSA's members who are providing other approved community support services but are not contracted by home care have not had an increase in their funding except as the net result of proxy pay equity offset by the social contract. Despite this hardship, many of our member agencies continue to

increase service to their clients to avoid the waiting lists that would otherwise develop.

Volunteers and staff in those agencies play a key role in meeting the agency's approved budget. Agencies with a strong history of successful fund-raising have the ability to consider expansion of their programs to meet local pressures for needed services if they have already met their budget requirements. For example, the board of directors may decide to pick up any deficit created by adding another Meals on Wheels route, foot care clinic or strengthening the visiting program. That flexibility seems to have been lost in the act, and it is essential to maintain a true community response to local needs.

We support the changes to the Public Vehicles Act which would allow our agencies to operate for the purposes of transporting persons deemed eligible by an approved agency. Many agencies will be grateful for the opportunity to provide van service to their day programs and other group activities.

However, we would be very concerned if regulations were developed which would in any way indicate a preference for transportation services to be provided by paid staff in agency vans or cars. In any given community, you can be sure that if there are three people requiring a ride to the doctor, the appointments are all at the same time, on the same day, to three different doctors in three different towns.

Given the absence of public transportation in many areas and the eligibility criteria for many of our agencies, clients who require escorted transportation would be at a distinct disadvantage if such a regulation was imposed.

**Mrs Dandelé:** Our clients in the community deserve to have legislation which will protect their interests as we strive to improve services to meet their needs. We believe our suggestions will strengthen the ability of communities to respond to our clients' needs.

OCSA members have been active participants in promoting long-term care reform. We applaud the leadership demonstrated by the provincial government in the development of Bill 173. We look forward to continued participation with the government and our communities to implement meaningful change for the people we serve. Thank you.

**Mr Gary Malkowski (York East):** Thank you for your presentation. You were talking about volunteer management. You're right, there's nothing in the bill that recognizes management of the volunteers. I'm just wondering, perhaps you have a recommendation in terms of volunteer management or coordinator that should be put into the legislation that may talk about the role of the coordinator as someone who would recruit and do those other things, or do you have another suggestion or a comment that you'd like to make?

**Mrs Fulford:** I think I would suggest that the distinct characteristics of volunteer management be highlighted in the legislation rather than a position. In any community, especially in the community support sector, you have different people with different roles within those community organizations, all of whom may carry an element of the volunteer administration role, whether they them-

selves are volunteers or if they're paid staff. So I think we have to be very careful about saying "a volunteer coordinator," but looking at those areas of responsibility that fall under volunteer management.

**Mr Malkowski:** Perhaps I could ask the parliamentary assistant to maybe take this back to the minister to consider an amendment to what they were just describing.

**Mr Wessenger:** Yes, we'll certainly take that under consideration.

#### RIDEAU VALLEY DISTRICT HEALTH COUNCIL

**The Acting Chair:** The next presentation is being made on behalf of the Rideau Valley District Health Council. Welcome to the committee.

**Mr Peter McKenna:** It is my pleasure and privilege to be present today to submit comments in response to Bill 173, An Act respecting Long-Term Care. I'm Peter McKenna, the past president of Rideau Valley District Health Council, and I would like to introduce my colleagues. Lorette Sutton is the chair of our long-term care committee, Peter Tudor-Roberts is the executive director of Rideau Valley District Health Council and Jo Harris is our long-term care planner.

I wanted more specifically to talk about section 62 of the act. Our council has already submitted a written brief regarding Bill 173. I have met with the past chairs of this council and current council members and I've also had the opportunity to discuss this response with the chairs of the six eastern Ontario DHCs. I want to briefly tell you a little bit about our community and the role of our district health council, but I wanted to start by saying that we're delighted to see this legislation, in particular section 62.

The Rideau Valley District Health Council was established in 1979, which means that we've had a presence in our community for the past 15 years. The DHC is very proud of its history of support and collaborative planning with the community. Lanark, Leeds and Grenville are rural communities situated halfway between here and Ottawa, for those of you who aren't familiar with the counties.

We play a key role in bringing our community members together to work on issues that have real meaning to our communities. Because of this role, a mutual respect has been developed with our community over the last 15 years. You will find that we have seen many programs develop and we're now seeing much collaboration as we plan for system reform. We were fortunate to have the first rural community health centre in the province and we were part of the pilots for both placement coordination services and the integrated homemakers programs.

As we engage planning for health systems reform, we as a DHC have never hesitated to tackle difficult issues. We have seven hospitals in our community and we are working with every one of them to rationalize and reorganize the hospital system. We have recently been highly successful in two particular hospital rationalization projects. For example, council has led the planning within the local community, which has led to the recent announcement of the plans to merge the Smiths Falls and

Perth hospitals and the review and rationalization of roles of the two Brockville hospitals.

As a rural district health council, we have long since recognized the need to work collaboratively with other district health councils in the area. We participate in the eastern area chairs' and executive directors' meetings. We were instrumental in the development of an area long-term care committee comprised of chairs and staff from long-term care committees of the six eastern DHCs. Rideau Valley District Health Council also works closely with the other eastern DHCs for all the major health reforms, including mental health, cancer, diabetes, substance abuse, health promotion etc.

As I said earlier, we are delighted to see section 62 of Bill 173, which will amend the Ministry of Health Act. It will strengthen our mandate and ability to work with the community. We would, however, wish to make a few suggestions to clarify the role of district health councils in their communities.

We see the community as an integral part of the district health council's role and functions and would like to see that added to section 62, subsection 8.1(4) on page 48. It could read, "The functions of a district health council are...to work with the community."

We also feel the functions should be reorganized to reflect the planning role of DHCs. I think that our legitimacy and our real strength come from our community and not necessarily exclusively from a mandate from the minister. Our strength lies in the people we serve. As part of the current role we are very much involved in assisting with the implementation of plans for reform, certainly in the evaluation of implementation plans, and we would like to see these included in the functions under subsection 8.1(4).

We also wish to raise some concern regarding clause 62(2)(d.1). We would like to see this read, "governing the recruitment and selection of candidates to be nominated for appointment to a district health council." Very similar to our colleagues in Kingston, we are concerned about the prescriptive nature that is implied when you get down to the committee structure the act is proposing, and we suggest that perhaps that section could end right at the end of "nominated for appointment to a district health council." By requesting this, we are asking that you remove the second part of the clause. This is very important to us as a community.

#### 1420

As we mentioned earlier, we have a strong history of working with community groups. This is done within provincial guidelines and in a manner in which it makes sense to our community. We need to ensure that the process remains responsive to the community and that we are not encumbered by a lengthy process. District health councils work with many community groups. Some of these are committees of councils and some are separate from council altogether but maintain linkages through staff and reporting structures, and some of the issues that we establish committees for are clearly local issues and often reflect collaborative efforts. DHCs need to maintain the flexibility in their committee structures in order to remain and be perceived to be responsive to local issues.

The current process of receiving direction regarding committee structures from the ministry is respected by this DHC and has worked well. We request that you act on this recommendation.

We'd like to suggest that the wording of this particular section of the act be reviewed by a joint ministry and association of district health council working group. Further, we would suggest that any of the regulations for the act which affect district health councils be developed by a joint ministry and district health council working group.

In summary, we wish to restate our pleasure in seeing the recommended amendment to the Ministry of Health Act through section 62. We feel strongly the need to adequately reflect the role of district health councils in working with their communities. It is imperative that district health councils are able to maintain a committee structure that is both responsive to the community and respectful of ministry guidelines.

Thank you very much for the opportunity to present to you today.

**Mrs Sullivan:** I'm interested in the concentration of the last two district health council presentations on a different approach to the mandate of being a representative body bringing opinion from the community and recommendations from the community with an accountability to the community, as distinct from being a body which this legislative approach would require that is an advisory body to the minister carrying out the mandate and directions of the minister.

I for one am disappointed that we don't have a separate bill on district health councils, because I think we have not through these hearings been able to give the attention to their mandates and resources and all the other issues that have to be faced with DHCs. I wonder if you'd expand more on that conflicting role that DHCs are facing every day.

**Mr McKenna:** It's a double-edged sword. When I've gone to the ministry with plans representing our district, the strength I bring forward is because of the community I represent and because I feel confident in the process that we've established. We've had wide consultation. The power comes from that process, because I feel that I've got the players, that we've discussed it right across our community. The strength lies in the people that we bring the message forward for. When we do that, we build credibility within our community, which allows us, when the ministry is proposing a change in the health system, to come and sit down and we've got the respect of our community when we bring messages or information or changes to the system back to our community. It is in the middle, and I don't know—that's just the nature of the beast. I can't imagine it being any other way, perhaps.

And I'm not disappointed that we don't have a separate piece of legislation for DHCs. I'm not sure when that would ever take place. That's why we're very supportive that this is here now.

**Mrs Sullivan:** I think the DHC conference and review process has just finished, within the past two or three months, and what I see as having happened is that that

discussion has been limited to the DHCs. There has not been major public participation in that entire discussion. It's people who are involved in district health councils who have participated in that. I don't think the average citizen knows what a DHC is. So when you're talking to me about trying to have the credibility within the community and therefore be an advocate for the community, that is a very different role and a very different function than what this law is going to require of district health councils.

**Mr McKenna:** I guess that's why we would like to see an added responsibility in there to the community that we serve, which is the ultimate master, I think, here. I don't know if you want to add any more.

**Mr Peter Tudor-Roberts:** If I could answer very briefly, we would support any legislation, however you want to tack it on to anything, as regards DHCs, because after they've been around 20 years, I think they've proven their point. I in particular, as executive director, am very proud of this DHC, because the people who work in this district seem to get on very well together and they seem to work collaboratively together, and that's a key part of our success.

I would agree that most people in the population, if they were asked what a district health council was, probably wouldn't answer, "Yes, I know what a district health council is." But on the other hand, we are not shy. If you go into hospital rationalization issues, you have to keep your head up and you have to be there to work with the members of the community. We have met in public consultations in our district with roughly about 350 people, and those items do make you well known. I think across this province, wherever hospital rationalizations are going on, it usually is a very well-known issue and the public get involved and the district health council is exposed.

I think the point, though, that we would say as regards any of the major issues, such as hospital rationalizations, is that the DHC has taken the initiative and taken the lead and that it's done with a collaborative cooperation of the hospitals, the hospital boards, the community health agencies. When we come to Brockville and when we come to Perth and Smiths Falls, one a merger, one a total rationalization, it's been done in a collaborative way and it's done in an all-inclusive way with the DHC firmly there in the centre facilitating the process. So we may not be known to everybody, but we are not shy about moving into difficult areas.

NORMA O'SHEA

**The Acting Chair:** Our next presenter is Ms Norma O'Shea. Welcome to the committee, Ms O'Shea.

**Ms Norma O'Shea:** I'd like to thank you for allowing me this opportunity to speak as a consumer. I am Norma O'Shea, a consumer and recent retiree from the health care field. As I note, the great joy of retirement is you can neither be fired nor short-listed for future downsizing.

From 1966 to 1992, I was involved in long-term care, and I've included my résumé there so you can get an idea of what areas I worked in.

As an avid supporter of innovative, cost-effective approaches to the delivery of health care services, I am deeply disappointed if this bill is what has evolved from endless hours of discussion, conferences and position papers during the past 10 years. A pack-rat by nature, I still have a folder labelled "Long-Term Care Reform." Reflection on its contents and the resulting Bill 173 leaves me wondering why it was necessary to have so much discussion and deliberation if the object was to dismiss and dismantle rather than enhance.

To construct and operate a totally new system to meet Ontario's diverse needs, rural, urban, ethnic etc, while remaining universally accessible and acceptable and cost-effective is virtually impossible. Supposedly, Bill 173 puts the needs and preferences of the consumer and their families first, allowing them to remain in the comfort of home and community settings. But will it? For how many, for how long, at what cost and to whom?

In many areas of this document, reference is made to "in accordance with the regulations." To which regulations does it refer? Is the document incomplete? Is a parallel document of regulations available? I am certain that the document was prepared to address any eventuality that might arise in the development and introduction of a multiservice agency, community services etc. I was and still am confused. However, I think part V outlines the approval of agencies to provide services that may be purchased by MSAs.

Part VI, page 11, indicates an approved agency may be an MSA, depending on the makeup of its board of directors. On reading the requirement for board composition, I wondered, as I have while working through this document, is the person mix in this proposed legislation of greater significance than the actual expertise in the services to be provided and delivered?

Section 13, page 12, describes the limitations placed on an MSA in the purchase of service from approved agencies to 20% of the budget for that particular component. Does that mean, if there are four agencies providing a similar service, they might each receive only 5%, or would one receive 20%? Is the economy so buoyant that this government can afford to put legitimate businesses out of business, let alone replace them with a totally tax-supported monopoly?

1430

Does section 15, page 13, of part VI mean an approved MSA could be in place for four years without either providing or purchasing services of any type for anyone? And what purpose would it serve from now until 1999?

Section 20, part VII, page 15: Many referrals for services tend to originate from hospital settings, such as emergency room, day hospital, inpatient. Who will assess for eligibility and when? Does the hospital have a responsibility to ensure that these services will be in place on discharge? If an assessment is made and eligibility denied, will a person remain in hospital or be discharged to home without service? The appeal process, once initiated, can take a minimum of 28 days before a hearing is held and a decision is reached and communicated to the involved parties. In a bureaucratic world this may be considered warp speed, but to the family hanging by their

emotional thumbs, this may well be an eternity both figuratively and literally.

Section 21, page 15, person's plan of service to be provided to the person in as timely a fashion as possible: What is meant by a timely fashion? Would the person remain in hospital an additional two to three days? Would they be sent home to manage as best they can until their assessed plan of care is implemented? This might well result in readmission to hospital and a need for reassessment with service delivery, again, in a timely fashion.

Waiting list: "If a community service outlined in a person's plan...is not immediately available" etc, they shall be placed on a waiting list for the services. Would not availability of services be due to (1) a qualified staff shortage, (2) budget shortfall, (3) program capping or (4) at the direction of the minister?

Section VIII, page 17, section 26, purchase of service and collection of fees from the recipient: Subsection (1) refers to community services, which could be any of the four listed in subsection 2(3) of part II, ie, definitions. Does this mean that if a person is assessed for services not available through the program, if the service is purchased by the client from a private agency, the cost would be at a rate fixed by the MSA, and second, assessed for services that are available but there is a dollar limit on the amount that the MSA will provide, per admission to the program or total per individual? If either is a correct interpretation, what happens to the person who has neither the money nor the insurance to purchase the needed community service? These are examples of questions I had as I read through the document.

While it espouses local initiatives which address the characteristic needs of communities and volunteerism, Bill 173 virtually destroys agencies that are an integral part of communities. The history of these dedicated pioneering agencies in the service of the people of Ontario predate the honourable minister and her party by many, many years. Long before elected officials responded to identified community health needs, our voluntary agencies and charitable institutions had recognized and were providing much-needed hands-on health care and health teaching in communities, both rural and urban. Historically, these unofficial agencies blazed the trails that were later followed by tax-supported official agencies in community health.

Bill 173, if enacted, will put at risk those most dependent on service, the frail, the elderly and the disabled, and it will wreak havoc on our current community health programs.

The haste with which this bill is being pushed through the Legislature and on to the people of the province of Ontario has everything in common with the charge of the Light Brigade both in logic and in outcome. In a cash-strapped province, why should any government plan to spend more than \$1 billion to fix what ain't broke?

*Interruption.*

**The Acting Chair:** Order. Ladies and gentlemen, I'm required to remind you that the parliamentary committees are deemed to be extensions of the House, and as such

demonstrations are not permissible. There; I've done what I'm supposed to do.

**Mr Conway:** But we heard you.

**Ms O'Shea:** Sizeable as this amount is, it is small change to the evaporation of donated dollars, person-hours and goodwill which will take place with the engineered closure of volunteer agencies and charitable institutions as proposed in this bill.

The honourable minister, in her June 6, 1994, press release, referred to "the confusion, duplication and patchwork approach to the provision of services across the province." I appreciate that for anyone living in the shadow of Queen's Park, it might be difficult to visualize how efficiently and effectively other communities have recognized and addressed, cost-effectively, perceived needs and deficiencies within their boundaries.

Kingston, Frontenac, Lennox and Addington and the adjoining tricoties of Leeds, Grenville and Lanark long ago developed a single-application, prioritized waiting list system. At user agency request, they put in place placement coordination services according to ministry guidelines. In 1967, a transportation system for the disabled was initiated, followed by a residence facility for the physically disabled in the early 1970s. Kingston Homes for the Handicapped Inc board of directors, committed to a belief in independent living where possible, envisioned apartment living with contracted support services based on assessed need. Through the combined efforts of this board, the Kingston housing authority and a for-profit community service agency, the Endymion project was realized in the 1980s. The management system and support services have changed in the past few years, but the concept remains the same.

These few examples suggest the current unique patchwork of community services spread evenly across the province may be more coordinated, integrated, user-friendly and cost-effective than any bureaucratic monopoly likely to be imposed by this particular bill.

As to support for the care givers, the Minister of Health, in applauding this legislation as enabling more people to receive care in the comfort of their home, assumes that the family members are available as care givers, that they are physically and emotionally capable of assuming this role and that the home lends itself to the provision of such care.

Changes in family structure and the economic climate ensure that working family members cannot be home to provide care or relief care in the long term. Care givers currently are on call 24 hours a day, seven days a week. A plan for affordable respite that includes scheduled relief hours, vacation times and emergency relief is essential for the emotional and physical health of both the recipient and the care giver.

1440

In earlier discussion papers, there was great emphasis placed on the enhancement of respite programs, their availability and their accessibility. I may have missed or not recognized its inclusion, but I found no reference to respite care in this document.

With the committee's indulgence, I shall make no

further reference to Bill 173 or the minister's press release, but rather address the human face of long-term care that has been my experience in the past 40 years, and particularly the last 30.

A number of initiatives have changed the provision of health care in time, place and outcome, but none more than the introduction of regional ambulance services with equipped, well-trained staff. The survival rate for both illness and accident dramatically increased, as did the demand for some forms of long-term care, in number and in level of care required.

A critical accident involving a young person usually results in the availability of intense support from family and friends during the first few years. The ensuing years see the once high hopes crystallize into no further improvement. Siblings and friends move on with their lives and what might have been described as the empty nest syndrome is replaced by aging, anxious parents agonizing over what will happen should anything happen to them. There are those who would say this is a role that loving parents readily accept, even though one or both may occupy a long-term care bed long before their time.

What of the young person? Is this the setting where his or her psychosocial needs can best be met? To date, we have provided a reassuring pat on the back but little else.

The disabling accident or progressively disabling illness for the young adult has quite a different face. Where this illness or disability occurs within the second or third decade of life, regardless of who is the disabled partner, this marriage or partnership will last no more than two to three years, while partnerships tend to remain constant where the same disabling event occurs in later life. During my years in long-term care, exceptions to this observation were rare and infrequent. The health crisis that resulted in the disability may be the same, but the demands on the health and social service system will be quite different.

Furthest on the age scale you'll find the elderly couple where the physical dependence of one is exhausting the other, both aware that it requires their combined incomes to keep their home or apartment afloat. Not infrequently, the issue is resolved with the care giver's deterioration and one or both requiring long-term care facilities.

Putting the needs and the preferences of the consumers and their families first may well not mean living in the comfort of their homes, for a variety of reasons. The system must remain insightful, sufficiently flexible to respond in as supportive and as humane a manner as possible.

The advances in both response time and treatment have increased survival rates and public expectation of what should be available to them at little or no cost. With bed closures, an even greater demand has been placed on our community health programs of all types. The proposed massive replacement of the existing system will be more costly and less flexible and will neither increase nor improve the services presently available.

Recommendation: If the government is unwavering in its commitment to Bill 173 as written, it is imperative that numerous well-publicized pilot projects should be

carried out to ensure that this new approach to community health care delivery is user-friendly, efficient and cost-effective before it is implemented.

I also assume that the \$1 billion set aside for Bill 173 could be better used to enhance existing programs, and the loss of volunteer dollars and time must be considered.

**Mr Villeneuve:** Ms O'Shea, thank you for having brought your many years of experience as both a worker and a volunteer, and I certainly commend you for your list of accomplishments here. I appreciate the fact that you have explained where you are coming from, the fact that you, in your own words, say, "If it isn't broke, don't fix it," or "If it isn't fixed, don't break it."

The situation you bring to us regarding volunteers, for example: Could you just put that into a little better perspective? If indeed 173 comes to the fore, what do you feel will occur to volunteers such as yourself, with a long list of accomplishments? Do you see them throw their hands up and say, "Really, it's in the hands of someone else"?

**Ms O'Shea:** Yes, I do. A volunteer is committed to a particular interest and perspective. I don't really feel that a rather nameless organization will attract that same interest. Plus, I think many of our volunteer agencies won't be there, as I read this act. Because they will only receive such a small percentage of the services to be provided, like 5%, there wouldn't be sufficient funding to keep the system going.

**Mr Villeneuve:** I gather you were not here this morning when we had presentations by a number of concerned groups that exist now. They're worried about their very existence, let alone being able to continue providing the services that they have over the past number of years. Now, you reside on Wolfe Island to this day yet?

**Ms O'Shea:** Yes.

**Mr Villeneuve:** And you bring a very real perspective from the rural part of Ontario, wish is vast, and I proudly represent one of those vast areas of rural Ontario. The autonomy to a degree that you speak of that you've had in the past you see pretty well being taken over by big government.

**Ms O'Shea:** Yes.

**Mr Villeneuve:** Therefore in losing the autonomy that you have had, or to a good degree, in the past, you see a deterioration in the quality of service that would be provided to those areas.

**Ms O'Shea:** What I see as much as that, sir, is that the identified needs that are unique to that community will go unnoticed or ignored in the overall big picture because it's the local interest that creates the volunteer and the willingness to put in the extra hours. It is growth from the bottom up. It's not from the top down, as this act is doing.

**Mr Villeneuve:** I think you've posed some very good questions with question marks. Of course, they're unanswered. Could I ask the parliamentary assistant if he and his staff would have a look at some of these questions that are unanswered in this presentation and possibly provide the committee with your thoughts on the replies?

**Mr Wessenger:** Certainly the whole planning process is designed to be with the district health councils coming up with the models to ensure a system that is responsive to the community. It has an approach, for instance, of community satellites and that sort of approach. Certainly the community itself is going to be determining what the model of delivery will be.

**Mr Villeneuve:** This is not what we're getting from—

**Mr Wessenger:** By having the planning process done by the DHC, we think that's the best way to ensure a delivery system that is responsive to the community.

**The Acting Chair:** Ms O'Shea, I wonder if I could ask you to make these your final comments, please, because we've run out of time; if you wanted to respond to the parliamentary assistant, that is.

**Ms O'Shea:** The final comment? The recommendation?

**The Acting Chair:** No. I mean, did you want to make a response arising from that last exchange?

**Ms O'Shea:** No. I feel that without regulations there, to review this act—it's very difficult to know just how it will affect a community. I have great fear that in order to save institutional dollars, cost of care, it just can't be moved to the community.

**The Acting Chair:** Thank you very much.

**Mr Conway:** Maybe we'll use the Wolfe Island ferry.

**Mr Gary Wilson:** What are you worried about, Sean? That's what you wanted.

**The Acting Chair:** That would require an entire other venture on the part of the government.

**Ms O'Shea:** I was going to wear my "No fare" button, but I—

1450

#### HASTINGS AND PRINCE EDWARD HOME SUPPORT NETWORK

**The Acting Chair:** Our next presentation will be made on behalf of the Hastings and Prince Edward Home Support Network. Welcome to the committee.

**Ms Jeanne Goodhand:** Thank you for this opportunity to speak to this legislation. My name is Jeanne Goodhand. I'm the executive director of Tweed and Area Community Care, a home support agency in the centre of Hastings county. I'm also the executive director of the only community health centre in Hastings and Prince Edward counties. I'm the chair of the Hastings and Prince Edward Home Support Network, on whose behalf I make this presentation.

With me today are Wanda Stringer, who is the executive director of North Hastings Seniors Home Support; Debbie Moynes, Prince Edward County Community Care for Seniors; and Barbara Clarke, Community Care for Belleville Inc. We represent the whole of Hastings and Prince Edward, right from the top to the bottom. You talk about remote and rural, we've got it.

The Hastings and Prince Edward Home Support Network was formed in 1987 to provide an informal connection of agencies providing home support services in the two counties. Since 1987, this group has kept well informed about local and provincial issues which affect

the delivery of a community-based service as well as parallel health and social service issues.

We're not VON, we're not Red Cross, we're not home care. We represent the agencies that organize those volunteers. We are the agencies that are called when a senior needs a ride to the doctor, help to bury their dog, help to fill out a form, someone with whom to talk, or a bat removed from their porch. We are the agencies that offer the supports that help the seniors stay in their own communities. We promote strongly wellness and the prevention of illness.

One key concern has been the involvement of volunteers in service delivery and fund-raising. Home support programs are provided by local, community-based, non-profit agencies. The supports we provide are flexible, personalized, responsive and least intrusive. They focus on health and wellness and are strongly centred on the client's need. They strengthen the ability of family and neighbours to support the choice to live in the community.

The programs provided include a broad range of practical support services designed to help the elderly and people with disabilities accomplish the tasks of everyday living. Our programs include information and referral, Meals on Wheels, congregate dining, friendly visiting, security checks, transportation, care giver support groups, intergenerational programs, home help, yard work, assistance with forms, advocacy, handy bus transportation, fitness groups, and others, believe it or not.

Home support agencies have strong accountability to local boards of directors and, through them, to their communities. Countless volunteer hours are involved in those service deliveries. We have over 2,000 volunteers working for the agencies that I represent today. These agencies are vibrant and viable and have deep roots in their communities.

We acknowledge that reform is necessary in the present system of long-term care. We ask you, however, to recognize, to celebrate the areas that do not require change, and one of these is volunteer involvement.

In discussing reform of long-term care as we know it now, we have identified the strengths and weaknesses we perceive existing in the current system:

(1) The home support agencies, as we now know them, depend heavily on a strong volunteer component. Many services are delivered not by paid staff but by willing, caring volunteers.

(2) Much of the funding for our services and programs comes from community fund-raising, again with a large volunteer component.

(3) The community, as we have defined it, represents specific serviced areas which are very distinctive in their needs, particularly in our rural communities. Programs are created to respond to a need identified by grass-roots support.

(4) The community, being responsible for the identification of specific needs, also therefore supports the necessity of local autonomy for accountability. Services are varied and dependent upon demographics, accessibility and geographic location.

The weaknesses of the present system:

(1) There is no protection for non-union employees presently involved in community-based services in the event that employees must be hired by a new system such as a multiservice agency.

(2) There is currently a lack of shared supportive and/or administrative services among providers. These services include payroll, human resources, purchasing and pay equity.

(3) Access to some services is confusing and frequently uncoordinated for the client.

(4) Client assessments are frequently duplicated, as they are performed by various agencies. This leads to frustration by the client as well as increased cost to the system.

(5) The present system does little to encourage team cooperation and collaboration in developing a plan of service for the individual client.

(6) Resources are scarce for volunteer management and development.

Non-union employee security must be a priority in less cosmopolitan areas where unemployment is already very high. In the document Partnerships in Long-Term Care, the guidelines for the establishment of MSAs which was released in September 1993, messages regarding the perceived preferential treatment of unionized employees in the new MSA became very apparent. Subsequently, in Bill 173 there are no references regarding the protection of not-for-profit, community-based employees as a result of implementation of long-term care reform.

Long-term care reform acknowledges the need for experienced, trained staff for the provision of services, yet the proposed process for development of multiservice agencies, along with social contract reductions and constrained finances, all currently have, or will potentially have, a negative impact on employment in the broader socio-healthcare sector. The skills necessary for community-based services are quite different from those necessary in the institutional environment. There must be a commitment to fair wages and benefits for employees.

We strongly recommend that client continuity and respect for the relationships between existing employees and consumers of service should be paramount. Consequently, the employee transfers to new agencies should be seamless, with no break in client service or provider employment. We further suggest that all employees of not-for-profit community support service agencies should be guaranteed comparable positions in the new service delivery structures without loss of seniority.

Volunteers have long been the backbone of community services and they must be recognized. Volunteerism is an essential component in the delivery of community-based services. The volunteer base must be recognized as being deeply rooted in the community and potentially fragile.

There is a lack of detailed planning in the legislation regarding volunteers and long-term care, even though there is a concern about an inadequate number of volunteers currently to support the expansion of programs and services. We recommend, then, that there be a recognition of the role of volunteers in the body of the legislation.

We recommend that volunteer management in regulation 11 should be expanded to require MSAs to develop and implement a plan for the recruitment, training, scheduling, supervision, retention, recognition and expense reimbursement of volunteers.

It is imperative that there be sufficient flexibility to allow communities to develop an MSA system to meet local needs. It is unclear what the final MSA model will look like in each community until the community planning process is completed. It is difficult to define the intent of the legislation. We are astonished that the legislation does not allow for local planning flexibility. It was our understanding that community responsiveness was to have been a necessary element of the developing process.

The district health council and long-term care planning committee of our area are actively promoting community involvement in planning for the future. The legislation suggests only one model for the MSA. Why then should our communities participate in this exercise of futility?

Community-based services have been traditionally driven by the needs of consumers. We believe that the legislation does not allow for a consumer-responsive or driven reform. We cannot support a single model for an MSA.

We believe that the MSAs must not be allowed to develop into large bureaucratic organizations. They must be small enough to be able to be responsive to local community needs.

We believe that there must be consistent standards developed or the unacceptable status quo will be maintained. We believe that the legislation must be amended to guarantee reform which is consumer-driven and that a responsive system becomes a reality.

We would recommend that members of our provincial association, the Ontario Community Support Association, be involved in the development of definitions of service to be provided, as these services are provided by our members. We would further recommend that our provincial association, OCSA, be actively involved in producing and approving the regulations to be developed for Bill 173.

**1500**

Having told you who we are, I emphasize the roots we have in our communities, which are manifested in our locally elected boards of directors and in our volunteers. Strengthened by this foundation, I must also emphasize that it is essential for the act to allow flexible models for MSAs based upon characteristics of communities. Let the people of our counties tell you what is local and what is a community; it's one thing that cannot be legislated.

**Mr Paul Johnson:** Thank you very much for your presentation. You gave us a lot of detail, certainly a lot of food for thought. I get the feeling there's a sense that how our communities associate with one another, how our communities interact with one another based on an urban model versus a rural model—I come from rural Ontario; I speak with my colleagues from urban Ontario, and for a short time I lived in urban Ontario. I just get the sense that communities know themselves better in

rural Ontario than they may know themselves in urban Ontario. Now, that may be unfair, but for the length of time that I've lived in rural Ontario, it's not unusual to know your neighbours great distances away and to know many, many neighbours. I don't think that same characteristic is prevalent in urban Ontario.

I raise that because when we talk about how Bill 173 will affect the people of Ontario, there is certainly a different sense from rural Ontario of how this bill may affect agencies that exist, agencies that are already doing a good job, as I know your agencies are, as opposed to agencies in urban Ontario, which may have a little different perspective on how they meet the needs of people requiring care under the long-term care provisions.

I know that Community Care for Seniors in Prince Edward county—the one I'm most familiar with because that's where I live—does a very, very good job. Indeed, even my mother is a volunteer.

Volunteerism in rural Ontario is phenomenal, just absolutely phenomenal. It just amazes me to no end. I'm certainly concerned when I hear comments like, "Volunteers will disappear if Bill 173 as it exists is enacted." I question whether that's factual or not. It's something that some people believe may happen, but I'm not so certain that's the case.

Also I hear that—and I think it was evident in your proposal or your comments today—there was a perceived lack of flexibility. Yet I, who advocate on behalf of agencies in rural Ontario, have insisted that there be flexibility within the programs under Bill 173. I hear conflicting evidence I guess. I hear the ministry saying, "Yes, there will be lots of flexibility; there will be all the flexibility that any agencies that exist could want," yet it's very fearful that indeed there isn't that flexibility. I wonder, even as I sit on this committee, which side is right. There are perceptions, and there's maybe some confusion.

If Bill 173 is enacted as it is presently—and we know through our deliberations that there are a number of amendments that are certainly wished for, and there are a number of amendments that I expect will be realized as a result of these proceedings—as it stands, give me the best example of how this will help you and maybe the worst example of how this will affect you negatively. You've given us a lot of information already.

**Ms Goodhand:** Probably the best way that it'll affect us is perhaps the washing away of the duplication of services, the joining together of all of the services rather than just individualized.

The worst scenario, I think, is the fact that we will lose volunteers. Volunteers have made it very clear to us that they serve our agencies. I think also what I'm afraid of, and I think we all are afraid of, is the loss of the local input, local autonomy, local boards. They're not going to be responsible to, say, an agency that's located in Belleville. It's long been known that we don't like to go to the city—I mean, if we could put it in the centre of Hastings. Anyway, that's an aside. I think that's probably one of the biggest things, the loss of autonomy of the boards as well as volunteers.

# HALIBURTON, KAWARTHA AND PINE RIDGE DISTRICT HEALTH COUNCIL

**The Acting Chair:** Our next presenters are presenting on behalf of the Haliburton, Kawartha and Pine Ridge District Health Council. Welcome to the committee.

**Ms Barbara Moffat:** We thank you for this opportunity of speaking to you today about Bill 173. My name is Barbara Moffat, and I am chair of the Haliburton, Kawartha and Pine Ridge District Health Council. With me today is Lesley Peterson, who is chair of our long-term care committee for Northumberland county. All of the material which we are presenting is in the kit which you have received, and we're providing a somewhat condensed version.

It's my privilege today to represent the many community volunteers who from Haliburton, Kawartha and Pine Ridge District Health Council offer their comments on Bill 173. Our council serves four counties. You have a map just inside your kit on the left-hand side which outlines our four counties. We are unique in this. We go from Northumberland along the lakeshore, Peterborough county, Haliburton county and Victoria county, from lakeshore to Algonquin Park. We have a geographic area of 11,416 square miles. Our counties are predominantly rural. Our total population is approximately 263,200, and we have a large percentage of seniors in all of our counties. We have three first nation reserves, and we have currently a high quality of services characterized by collaboration among our provider agencies.

In its strategic plan, the Haliburton, Kawartha and Pine Ridge District Health Council expresses its commitment to the very sound principles guiding the long-term care reform. Even before the large provincial consultation in 1991-1992, our council had developed a process for long-term care planning that foresaw the creation of committees of consumers, service providers and others to plan and advise on issues affecting seniors and persons with disabilities.

With the advent of the long-term care committees outlined in the ministry's partnerships and planning policy papers, our DHC put its four county-based, long-term care committees into action. Members of these committees generally agreed that the long-term care system needed change and a legislative basis for that change. We now have the legislative basis in Bill 173. However, we do have some concerns with the bill, which will be outlined specifically by Lesley Peterson.

1510

**Ms Lesley Peterson:** We have four major concerns today. I'm going to list those concerns, and then I'll backtrack and enlarge on each one. Our first concern is the changing role of the district health council and the enshrinement of its functions in Bill 173. Our second concern is around lack of flexibility and quality of advice. Our third concern is the one you're hearing most about it seems this afternoon, and that is volunteers. Our fourth concern is staff and labour issues.

I'd like to start with the changing role of council. The first of these concerns is the question of why the role and functions of district health councils are being enshrined in legislation that deals only with long-term care. Health

councils deal with all determinants of health, not just for seniors and disabled persons. Multiservice agencies are not the only projects and planning in which they are involved. Our district health council's network of community volunteers addresses rural wellbeing, addictions, mental health, youth, hospital restructuring, injury prevention and rehabilitation, and you will see examples of all these activities in the handout that's been provided. We suggest very strongly that Bill 173 is not the appropriate place to legislate district health councils, or if this is not possible, that the bill be amended to reflect the wider scope of the councils' planning function.

On page 49, part XII, section 62 of the bill, dealing with council roles and functions, does not address the reality of the changed roles of councils as a result of the demands of the long-term care reform. Particularly with the lead in developing the multiservice system, they are moving into implementation planning and away from their traditional role of health system and project planning. We recommend that further discussions be held with the ministry to strengthen this section of the act to reflect the new expectations of district health councils and to prevent them from being perceived as yet another arm of government.

Our second concern is the potential in the legislation for restriction on the district health council's ability to represent the voice of the community and its local vision for health and social services. Such restriction could affect the quality of the advice our council is able to offer the minister. The following provisions of Bill 173 pose a potential for such restriction.

On page 6, part II, section 2, the listing of mandatory services leaves little local latitude to develop a multiservice system uniquely appropriate to local needs and culture. Our area is probably the most rural of all the district health councils in the province, with all that means in the way of lack of public transportation, non-urban attitudes and the additional costs of service delivery.

The list of regulations on page 36 in subsection 56(1) has the potential for further limiting the flexibility that district health councils need in planning a multiservice system that truly responds to local needs and realities. We encourage you to respect that flexibility by including councils in discussions formulating the regulations.

On page 49, in subsection 62(2) there is a need for clarification. Does this section mean that the ministry will have a say not only in appointment of council members, which is appropriate, but also in the recruitment and selection of subcommittee members, which through experience we suggest is unworkable and an unnecessary level of control? I think we have currently about 40 subcommittees. Just the logistics of helping to choose subcommittee members for 40-odd committees is horrendous. We propose that reference to subcommittees be deleted from this section of the bill.

Our third concern pertains to volunteers, and I've been hearing in the last 20 minutes or so most of the concerns that we have expressed, but I'd like to present them to you from a slightly different perspective.

Paragraph 56(1)11 is the only reference to volunteers in Bill 173. The life support of many service provision

agencies and the group upon which the council relies heavily to carry out its functions is probably not getting a fair deal in this document; they are the council, and council cannot function without its array of over 300 community volunteers. With this legislation, an inappropriate level of responsibility is being placed on volunteers. Yes, they do act in an advisory capacity, strictly speaking, but in the bill there is no acknowledgement of the role of volunteers in the multiservice agency, no reference to their responsibilities in service delivery and no protection for council volunteers, especially when it comes to their responsibilities and potential liabilities when recommending on allocation of funding. We request that this issue be discussed with councils and included in the sections of the legislation touching on multiservice agencies.

With the integration and amalgamation of agencies envisioned in the multiservice agency, the recruitment, retention and attachment of volunteers is threatened, and they cannot and must not be lost in the shuffle. As well, the potential for fund-raising could be weakened if multiservice agencies are perceived as quasi-governmental agencies, and this perception must be avoided. I know the previous speaker alluded to that very strongly.

Regarding staff and labour issues, there will inevitably be some dislocation of the labour force in the transition to the multiservice system. Besides volunteers, employees in affected agencies must be protected, not only the unionized ones but also the non-unionized workers. This has been well identified by previous speakers, and we heartily endorse those concerns.

In conclusion, the Haliburton, Kawartha and Pine Ridge District Health Council believes that the changes and additions to Bill 173 that it has suggested will enhance council's mandate to give good, community-based advice to the minister, advice that will (a) maintain council's honest broker role in the community, (b) define and protect the integrity of its planning functions, (c) recognize and protect the importance of community volunteers and non-unionized staff and (d) will establish a multiservice system that truly responds to the needs and circumstances of our local communities.

We trust that our constructive suggestions and comments will enable both the Ministry of Health and the district health council to better serve our public. The fuller version of this submission is in the handout that has been given to you. Thank you for the opportunity to present this afternoon.

**The Chair:** Thank you very much for your submission. Mr Conway.

**Mr Conway:** Thank you very much, Charlie. "Charlie" sounds a lot better than "Mr Chair." I refuse to refer to my friends as pieces of furniture.

**Ms Peterson:** What would you have said if I'd sat down and said, "Hi, Charlie" as my speech?

**Mr Conway:** I would've been impressed, actually.

**The Chair:** I might've been surprised.

**Mr Conway:** Think about it; think about referring to one of your colleagues as "Mr Chair." Anyway, where I come from, chairs are pieces of furniture.

I look at your district, and I know it reasonably well. I'm from Renfrew, which if anything is even more rural, so as I look at the catchment area of your district health council, I'm trying to understand the status quo pre the implementation of, say, Bill 173. Let me just say that in the county of Haliburton are a lot of these services that are intended to be controlled by the new MSA. How are they now delivered in a place like Northumberland or Haliburton? Would it be the local health unit that would be doing a lot of the program delivery now?

**Ms Peterson:** No. I would say that these programs are fairly evenly divided pretty much as the bill lays down. I think we are referring back to the comment made by a previous presenter that these services in many areas do exist, are being performed extremely well and may require definition and streamlining but are currently there. In our area, we have a very strong health unit. We have very strong community care. We have Red Cross. We have VON. We have many agencies that do meet on an informal basis and do provide, without a whole lot of duplication, those services.

1520

**Mr Conway:** What concerns me about this—I'm just a visitor to this committee, but I've listened to a couple of days of hearings and I think there clearly is a consensus out there and in here about some of the basic ingredients of long-term care reform. I don't think that's an issue any longer. I think the real concern is about the instruments to get from here to there and some kind of a read of the financial context in which this is all going to develop.

In an area like mine, for example, the health unit is a very key deliverer of many of these programs. All kinds of people around my communities, particularly in the big rural areas, say that if we go ahead with Bill 173 as it's currently written, and this deals with some of the staff labour questions, for the first two or three years of the new order we are going to be faced with a situation of complete paralysis. There is going to be nothing much done other than everyone trying to figure out where they go in the new scheme of things. The delivery of these vital services to needy people in small communities and rural townships will essentially, if not stop, certainly grind to a much, much slower pace while everyone goes to court or the Ontario Labour Relations Board to figure out where they fit in the overall scheme of things.

**Ms Peterson:** May I respond to that? I don't think you're giving enough credit to the service providers. I think the concern of all the service providers that I've met with over the last year, and I've talked to plenty, is the client.

**Mr Conway:** But let me ask you—let's say you had a health unit that was not going to continue for whatever reason to deliver any of these services, that there was going to be a transfer to some other organization. What do you think is going to happen there over the course of the first two or three years? My experience in nearly 20 years in the Legislature, whether it's in school affairs or—there is a very real concern about what happens to me and my job.

**Ms Peterson:** I think that concern is there, but I don't

think it stops people from delivering service. In the hypothetical situation that you have mentioned, a difficult one to think of in our area because our health unit is not only strong, it's very cooperative and works with all the other agencies—but if you had that situation arise, I think you would have to remember that most of these services were founded from the ground up, were delivered originally from the ground up. You would simply find people coming out of the woodwork, coming together and saying: "We're going to have a gap here, a loss in service. What are we going to do about it?" And history would repeat itself, because this is how most of us got started in the first place.

**Mr Conway:** I look at places like Haliburton. I'm trying to imagine that if we disenfranchise certain players, and I'm up in north Hastings, west Renfrew, east Haliburton, who else is there in Carlow township or in some of these places? It's not exactly a great list of possibilities. Some of what we have may be imperfect, but if they're going to be, for whatever—I'm thinking of health units, because in my area they are a very significant—if they're disqualified, I'm trying to think, who is it going to be?

Why would we go through this misery of getting everybody upset just to try to recreate more or less what we've already got? My great fear, based on a lot of experience, is that we would spend months and years and hundreds of thousands of dollars to end up not quite where we were when we started. We'll have a lot of tax-paying constituents trying to figure out: "So you're from the government and you're here to help me. Go to hell," they will say, rightly so.

**Ms Peterson:** Have some faith in your district health councils. The process is a sound one. Most of the district health councils, I understand—I can only speak for our own, on which I'm a volunteer—are working very hard to put a planning process in place where the example that you've just given could never happen.

**Mr Conway:** But I've got to tell you that my experience with a lot of planning—they're good people, but this is in downtown Haliburton. This is going to be real interesting raw politics. I meet my grandmother and she's furious, because that nice person who has been looking after her for 15 years is just gone and there's nobody yet to take her place. They don't want to talk to the district health—they're going to want to talk to Villeneuve, Wilson, Conway, Hodgson, you name it: "What the hell is going on here? I've just seen too much of this from quite frankly all levels of government. Those good people at the district health council are just that, bureaucrats and planners. I pay taxes. I had not a bad service and it's gone."

**Ms Peterson:** Do you want to go outside for two seconds?

**Mr Conway:** Let me be very frank. I remember my dear old friend Billy Davis announcing a school policy once, and I was the happy soul who went around the province for two years explaining to people what this joyful noise was all about. And you know what? There was a gap between promise and performance, and a lot of people on Main Street, Ontario, had figured it out a lot

sooner than a lot of the politicians. On stuff like this, delivering really significant, sensitive programs to the elderly, I don't really want to make a miscall, if I can avoid it—

**The Chair:** On that positive note, I think—

**Mr Conway:** Sorry.

**The Chair:** —in order to move Mr Conway from the misery in which he was—

**Ms Peterson:** From which he's just put himself in.

**The Chair:** Yes. I think I will allow you a last comment and then we'll need to move on. Was there anything—?

**Ms Peterson:** Tell him he's wrong in two seconds?

**The Chair:** Yes.

*Interjection.*

**The Chair:** In here or out there?

**Ms Peterson:** I hope there's nothing you know that I don't know coming to these hearings, because what I'm reading in Bill 173 and what I'm hearing in our planning process precludes the kind of scenario you're talking about, and if I didn't have faith in that, I wouldn't be sitting here and spending hours working through the process, and I'm glad I'm not a politician.

**The Chair:** Thank you.

**Mr Conway:** We've heard a lot of evidence here to suggest that there's a lot of worry out there.

**The Chair:** We thank you very much, both for the presentation and also the other attachments that you've made to the documents.

**Ms Peterson:** Thank you very much.

**The Chair:** Thank you.

**Ms Peterson:** Thank you, Charlie.

**The Chair:** Yes.

**Mr Malkowski:** On a point of order, Mr Chair: I just wanted to take the opportunity to thank the speakers for educating our members in the opposition parties. Perhaps maybe they'll use those thoughts wisely.

*Interjections.*

**The Chair:** Order.

**Mr Paul Johnson:** This is a legitimate point of privilege.

**The Chair:** Okay.

**Mr Paul Johnson:** I didn't hear that immediate point of order, if it could be repeated, so I could hear it. It was because of the noise.

**The Chair:** Okay. Could we just repeat the point of order?

**Mr Malkowski:** Oh, you want me to say this again. I just wanted to thank the last presenter for maybe educating our opposition members and maybe some of this information will come in useful.

ROYAL CANADIAN LEGION, ONTARIO COMMAND

**The Chair:** I call the Royal Canadian Legion. Gentlemen, welcome to the committee. Mr Margerum, I know you've been before the committee before, I think on Bill 101, and we welcome you and your colleagues today.

**Mr Jim Margerum:** With me is Comrade Earl Kish, who's our deputy district commander from the Kingston area, and Comrade Jim Mayes, who is veteran services chairman for district G, which is eastern Ontario. I am the veteran services chairman for Ontario Command.

My initial comment is, ideally, I believe there are possibilities in Bill 173 and it's on the right track. However, I believe there are a number of things realistically that will not work and certainly need to be revisited and amendments made. I believe if you're listening to the presenters here, you will find a large amount of material that can assist in resolving it and making it a workable proposition.

For the information of people here, we represent 173,000 members across Ontario. We provide three million volunteer hours a year and we donate approximately \$19 million in donations. Our involvement is in housing, Meals on Wheels, hospital, medical centres, youth, club scouts etc, adult sports, canvassers, volunteers for fund-raising, seniors' activities, seniors' care such as foot clinics, transportation, income tax assistance etc and we provide our branch facilities for community activities. We are members of boards of directors, communities, auxiliaries and sick visiting shut-in groups of hospitals, youth and senior organizations.

While we fully support some of the complaints and concerns as presented by numerous groups, we represent a particular group of veterans, but I would ask you to bear in mind, if you're looking at adult males over 70 in the province of Ontario, three out of five are veterans, so it has a significant impact on seniors and their spouses, which is our concern.

Representatives of this legion committee appeared before the standing committee on social development when Bill 101, An Act to amend Long-Term Care, was being discussed in public hearings. We will leave with the members of this committee on Bill 173 the briefs we presented then and copies of a review report prepared on the long-term care facilities program manual, which details many of our concerns, then and now.

Level 1 care, which had a particular application to Canadian veterans, no longer is recognized with respect to admission to long-term care facilities. An exception to this is the agreement to grandfather those veterans housed at the Rideau Veterans Home in Ottawa.

Our concerns with Bill 173 are primarily the same ones expressed in our briefs on Bill 101. The legion said then, without particular mention in the act of recognized rights enjoyed by veterans, those rights would fade away into the sunset in Ontario and eastern Quebec. We see this happening now and again are concerned that the situation will worsen if this bill, as proposed, becomes law. Administrators and others who operate exclusively under the language before us cannot ignore the well-earned rights of veterans seeking care in Ontario.

1530

We have had meetings with the provincial Minister of Health and her staff, as well as with Veterans Affairs Canada, to attempt to work out a solution to this growing problem. While not trying to be adversarial, we must

strongly insist that veterans' rights should be expressly recognized in the acts and regulations so they cannot be overlooked unintentionally or otherwise. The two levels of government have engaged in an exchange of letters which they indicate to us will suffice in allaying our concerns on behalf of veterans. However, if the operating staff or administrators are not directed regarding veterans' special rights, they will become part of the general citizen group and their rights will dissipate and perhaps die.

Veterans Affairs Canada assures us that the veterans' health care regulations will continue to be the sole admission criteria to be met where veterans are to be admitted to veterans' priority beds. With due respect to their declarations, we can find no language in the current act, the long-term care facility manual or the bill now being considered, which anyone may read, to come to that conclusion. As we see it, the community is simply not equipped to handle the load implied by the current bill which, in turn, fails to recognize the special group of veterans. By not recognizing in Ontario legislation the acquired rights of veterans in Canada, the accelerating question arises: Where will our veterans go and who is to ensure the services and benefits contained in the veterans' health care regulations?

Our committee has already corresponded with federal and provincial administrators concerning the newsletter, *Reaching Out*, published by the Ottawa-Carleton Regional District Health Council in July 1994. It is, in part, on the question of admissions, raising great concerns on our part. We leave you with copies and will elaborate in any questions on this particular comment. I refer to the fact of admissions where the placement coordinating person can in fact overrule a medical diagnosis of a doctor.

Bill 173: We have explained that in respect of the existing act and Bill 173, our main concern is one of omissions. Example—no formal recognition of veterans and their special rights. Unless that principle was to be incorporated, then specific comment as to existing language and possible amendments would be futile. We are confident, however, that should the principle of formal recognition be considered, language changes could fall in place.

A few sections do raise questions in our mind and we would like to address them, notwithstanding our general comments.

Under definitions, a "service provider" includes minister where funding and approvals are provided, and the act, clauses 6(a) and (b) state the minister may operate and maintain facilities.

The question: Where Veterans Affairs Canada funds and provides, directly or indirectly, care to veterans, where is it recognized under Bill 173? Is there in fact any recognition of veterans' priority beds in any long-term care facility contemplated by the act, and primarily the admission?

Part III, Bill of Rights, lists a number of rights which must be ensured by a service provider. Paragraph 3(1)3 recognizes certain rights arising from the "cultural, ethnic, spiritual, linguistic and regional differences." These probably arise from other legislative rights, federal or provincial.

Question: Could it be that veterans' rights under the veterans' health care regulations may, in like manner, be formally included under this or a separate section?

Those sections dealing with multiservice agencies and placement coordination services make no mention of veterans' rights under federal legislation. These are operating groups responsible to apply conditions of admission and care in long-term care facilities.

Question: Where is the legislative or regulatory language which they will apply in respect of veterans and, in particular, to those occupying—if they meet whatever admission criteria—federally supported contract beds?

Summary: We trust our brief representations here, together with the other material we have provided, will serve to demonstrate the growing concerns we have in regard to developments we feel arise from no recognition of veteran rights in provincial legislation and regulations affecting them. We do not believe systems and programs are in place in Ontario to handle extended care requirements in the community. By that, we refer to the institutionalization of people and returning them to the community. There are no sheltered or domiciliary care infrastructure and facilities to handle that particular area.

By not recognizing and dealing with this special group of citizens, the veteran population, the government is burying its head in the sand. We stand ready to cooperate and work in conjunction with the ministries and others to develop such infrastructures and the necessary independent facilities for veterans, seniors and the less fortunate.

In closing, we wish to express our appreciation for having had the opportunity to appear, and we trust our efforts on behalf of veterans will have a positive impact on your deliberations. Thank you.

**The Chair:** Thank you very much and thank you as well, as you mentioned, for the submissions you made when we were reviewing Bill 101 which are in the back of the document you have passed on to us.

**Mr Jim Wilson:** Thank you, gentlemen, very much for appearing here on behalf of veterans. I recall very much your presentation during the hearings on Bill 101 and we were able, at that time, to put forward amendments in support of the Royal Canadian Legion's position at that time. However, I'm just trying to recall, we weren't terribly successful. I think they all got voted down. Could you tell me—there was the side agreement that you've mentioned with respect to the grandfathering of some veterans in the Rideau—what do we call it?

**Mr Margerum:** Rideau Veterans Home.

**Mr Jim Wilson:** Yes. But other than that—you're right, your concerns here today are very much concerns that were expressed under Bill 101. You mentioned today that you've had meetings, I gather subsequent to Bill 101, with the Minister of Health. I'd really like to know what kind of answer you're getting from the Minister of Health and why the government, to date, has not put special recognition in here for veterans. What kind of answers are they giving you?

**Mr Margerum:** In fairness to the ministry and Veterans Affairs, we did in fact receive very comprehensive answers. The difficulty we have is, and I guess we

agree to disagree, they say our fears are unfounded, but our argument is, if it's not in the written word, it's in the hands and the heads of those who are interpreting it.

I'll show you an example. Both the Minister of Health and the Minister of Veterans Affairs—or I guess they call him secretary of state from the American changeover in federal politics in Canada; they're fast becoming Americans. Their comments to us were that a person who was going to be admitted to one of these contract beds, if Veterans Affairs Canada health care regulations stated they could get in, that would be it. We disagree because the legislation states that the placement coordinator will determine. As an example, it states in that article in July that there's more emphasis for the placement coordinators and that a placement coordinator can—even though a medical doctor has assessed the person to be admitted, if in the opinion of the placement coordinator the person can be served at home, that's where he'll stay.

I'll give you an example, and I would ask the question of everybody at the table what you would do. We have a 90-year-old veteran who has just been diagnosed in an acute-care facility on Friday. He's dying from cancer. He has from one week to two months to live. His wife is 79. She's had a number of heart attacks and is in a difficult state. I phoned her at 9 o'clock this morning and she has told me the unfortunate circumstance that he's passing away. It has taken two months to get him into the acute care hospital.

**1540**

He is a veteran; he is entitled to admission. He wasn't admitted because there's no room. However, it took that long to look after him, and the most astounding part of it is the fact that one of the doctors there, one of the staff at the hospital, the acute care hospital, asked the lady, if she would take him home, they would look after him. He's on intravenous continually and he takes strong doses of morphine. I ask anybody, is that fair to put that person back in the community on a lady who's not well, 79 years old?

That is the kind of concerns that we have. We just feel that it's beyond comprehension to put people in the community if the services aren't there to look after them. Fortunately, VON and other support agencies are going there, but they're six days a week during the day. They're not there overnight. This lady was in a real state of panic when she called me this morning.

**Mr Jim Wilson:** The real-life case you bring to our attention is very disturbing and it highlights that you're not just surmising that veterans are losing their special rights, but it's actually happened out there. That's what we need to hear, because I sat through the hearings, as you did, and the assurances given last year by the government with respect to the first phase of long-term care. What you're telling me, though, is that veterans are subject to the same medical test to get into a bed, whether it be an acute care hospital or a nursing home, as everybody else, and that the special rights have been eroded.

I will ask the parliamentary assistant to respond to that, because that's very disturbing and contrary to what we've been told.

**Mr Wessenger:** First of all, we should be clear that the issues that are being raised have nothing really to do with Bill 173. They relate to facility beds, and there's nothing in the bill—

**Mr Jim Wilson:** Except that placement coordination service is what he referred to, and that comes under the MSA.

**Mr Wessenger:** That's under Bill 101 as well, placement coordinating services—

**Mr Jim Wilson:** But it becomes assimilated under MSA.

**Mr Wessenger:** —so this bill is no reference.

However, with respect to the question of the facility beds, as you may recall—I'm doing this from memory, so if I don't present the total details maybe Mr Quirt could, who is probably more familiar—the concern that was raised during the previous hearings was about the loss of beds in particular institutions, three hospitals. Perley was the one that was most in note, and I believe there's one in London, and Sunnybrook in Toronto. There was concern that these preferences for the certain number of beds that were in an agreement between the federal government and the provincial government were not adequately protected. I believe, if my recollection serves me correctly, that there was an amendment that went through with all members' support to clarify the protection. I think I'm correct there. I'll ask Mr Quirt if there's anything he can add.

**Mr Geoff Quirt:** Currently the province ensures with an arrangement with the federal government that there be priority access for veterans to beds in three hospitals: one in London, Sunnybrook in Toronto, and the Perley Hospital in Ottawa. As you know, the Perley Hospital in Ottawa is undergoing a redevelopment, and when a brand-new facility is built, it will be funded as a long-term care facility and governed under the provisions of Bill 101. Even though Bill 101 currently doesn't fund any priority access beds, if it is used to fund, and when it is used to fund the Perley, it will continue to guarantee priority access for veterans. That's why there was an amendment specific to that facility introduced for Bill 101.

Mr Margerum and others raised the issue of language in the transfer agreement between the federal government and the provincial government, pointing out a particular clause that might have been construed otherwise. We took it upon ourselves to confirm in writing from the Minister of Health provincially to the federal minister saying that the Minister of Health or PCS had absolutely nothing to do with who went into those priority access beds, that it was clearly a Veterans Affairs responsibility.

We received correspondence back from the federal government that said: "Yes, it's totally our responsibility. The province has got nothing to do with it." Both those letters are in the possession of the Legion, I understand. I'm not sure what other form of assurance we can provide, other than to say it was our intention to amend the bill, and we did do that, and put specifically in the transfer agreement that Veterans decide who goes in regardless of what a physician says. It's clearly up to the

federal government to decide who gets access to those beds.

**Mr Margerum:** I would just read you a passage of the statement. If that is in fact the case, then the district health council in Ottawa should really be checked up. I'll read you verbatim what it says: "The legislation also provides for a stronger role for PSCs in authorizing all admissions to long-term care facilities. Although physicians—which in this case would be Veterans Affairs Canada senior medical officers—"will continue to complete a medical report as part of the assessment of need, the placement coordinator is required to document whether or not a person's needs can be met by existing community services in determining their eligibility for admission."

It says to me that the admission is determined by the placement coordinator. Even though they're eligible, the admission to the facility is determined by the placement coordinator.

**Mr Quirt:** The placement coordinator determines admissions to all long-term care beds in Ontario with the exception of the beds that will eventually be funded—aren't funded now, but will be eventually funded—by Bill 101 in the new Perley long-term care facility. The PCS will have nothing to do with and nothing to say about who gets into those veterans' priority beds in the Perley.

**Mr Margerum:** Well, I would appreciate that in writing that the admission—and we're talking admission, not accessibility.

**Mr Quirt:** The Minister of Health thinks she's written to you specifically with that message, and she will write again next week.

**Mr Margerum:** Okay, thank you.

**Mr Jim Wilson:** Well, now I'm a little confused, because the 90-year-old gentleman that passed away, should he have had admission?

**Mr Margerum:** Our concern on that was that this gentleman was in dire straits, which has been confirmed by medical authorities. His wife was in a panic state when she called me, and it took considerable time to get her in there. I'll leave it at that.

**Mr Jim Wilson:** Right.

**Mr Margerum:** The other concern we have that is rather obvious, I'm sure, is that once and if and when the MSA system is in place, is their decision on placing people going to be determined by budgetary restrictions or by the medical and genuine need of the individual? That's a question I ask.

**Mr Jim Wilson:** It's a good question, and it's one where I think the answer is probably a combination of the two. We don't know as members of the committee what the eligibility criteria are, and that's a problem. I will give the parliamentary assistant a moment to answer that on behalf of the government, though.

**Mr Wessenger:** Well, I understand there's a working group being established to develop the criteria. I'll ask Mr Quirt to again indicate, and I think he has indicated on previous occasions with respect to that.

**Mr Quirt:** Mr Wilson, are you referring to the eligibility criteria for admission to a long-term care facility or the eligibility criteria to receive services from a multiservice agency?

**Mr Jim Wilson:** Well, to date we've been given a rough outline, I guess, of what the committee is looking at in terms of putting together what the current eligibility criteria are on both fronts and, secondly, what the government is envisioning or what the committee might come up with. We don't really know the answer to that. I don't know, Mr Quirt, whether you can enlighten us any further on those, unless the committee has done something miraculous in the last week or so.

**Mr Quirt:** Well, certainly the admission criteria for long-term care facilities are in place now and have been for some time—

**Mr Jim Wilson:** Under Bill 101?

**Mr Quirt:** —under Bill 101, and we'd be happy to remind you about those. My staff presented to the committee on the work to date on clarifying the eligibility criteria for MSA services. As you know, one of the themes behind those eligibility criteria is to provide services that allow people to remain independent in their home and avoid institutionalization, and there's some further work that needs to be done on the threshold for when services are publicly funded and so on.

As was presented to the committee, a fair bit of work has been done already and a group with a number of stakeholders represented, including people who bring in both a provider and consumer perspective, is continuing to work on the eligibility criteria. They'll be contained in the multiservice agency manual that's under development by those 11 work groups we mentioned earlier.

1550

**Mr Jim Wilson:** I appreciate your response, except just going back to the real-life story that was presented here, I think the concern was that the gentleman was not in very good shape at all and neither was his wife, and that he was being essentially told to stay in the community because supports might be available in that community.

Now, you've got your eligibility criteria, and I do recall them very well, in Bill 101. It's to me a very high test, and we had a lot of discussions about that, so you're kind of blocked from getting into the institutional side of health care with that test if there are community services available. How do you respond, though, and I ask the parliamentary assistant, to that scenario? How much weight is given to the 79-year-old spouse at home who's not able to cope and we're told community based services aren't in place? That should have been an admission according to the eligibility criteria that are in place now. It shouldn't have been a two-month delay.

**Mr Wessinger:** Again, I will answer initially and maybe Mr Quirt will add some facts. But the relevant situation, I would suggest, is, first of all, are they admissible? Their doctor has to determine whether they should be admitted to hospital or not. In the question of a palliative care situation, certainly the community support services were available, I would suggest, in the community.

I think the suggestion was that the community support was maybe not the most appropriate in the circumstances, that maybe a facility option should have been there, and that of course would depend on a placement coordination.

I guess there would have to be an application to a facility. If it's considered to be of an urgent need and appropriate, and a bed is available, then of course the placement would occur. I don't think there would be any question that somebody in those circumstances would be eligible for a facility placement. There's no question of eligibility; it's just a question of what is possible and what's available at that moment.

**Mr Quirt:** First of all, if the gentleman that Mr Margerum referred to was a veteran, our eligibility criteria would have nothing to do with him getting in the Perley Hospital, where those priority access beds are. That would be clearly up to the federal government's Veterans Affairs people to determine where that gentleman stood in terms of their waiting lists for those priority access beds in there.

If the other options were to be explored, if the gentleman and his family were interested in other long-term care facilities and if he was requiring palliative care in a hospital bed and if care givers at home were having difficulty in coping, then I suspect this client would qualify as a priority admission under our new eligibility criteria, which tend to make sure those people most in need of facility services are first in line.

**The Chair:** Mr Margerum, and then I regret we're going to have to move on.

**Mr Margerum:** Very quickly, I should inform you they are the only two survivors of the family, the husband and wife. They have no living relatives.

The second comment I have is, I realize the Minister of Health and the Minister of Veterans Affairs have written and stated something in a letter. But if you look at that article from district health council, the message hasn't got there, primarily because of the absence of the reference to veterans, period.

#### LEEDS, GRENVILLE AND LANARK HOME CARE PROGRAM

**The Chair:** I next call on the representatives from the Leeds, Grenville and Lanark Home Care Program. Good afternoon and welcome to the committee.

**Mrs Connie Lendrum:** I would like to thank the committee for giving us the time to make this presentation today. I am Connie Lendrum and this is Lois Patchell. We work as case managers for the Leeds, Grenville and Lanark Home Care Program. I am here to speak on behalf of our home care program and case managers.

The word "reform" implies improvement. We who work in the system you aim to reform would agree there is much room for improvement. However, we do not think that throwing the baby out with the bathwater is the way to go.

We presently have a health care delivery system that took 20-plus years to develop. In our tricity area, we have the home care program, placement coordination service, 12 home support programs, two non-profit nursing

agencies, one non-profit homemaking agency, three commercial agencies offering homemaking and nursing services, one Alzheimer outreach program, one non-profit attendant care program, three hospice volunteer visiting programs, three elderly persons' centres and a multitude of volunteer-based agencies. These agencies know each other well and work together with great cooperation to meet the needs of 144,900 people in the area.

The proposed MSA structure will take this sophisticated culture and virtually wipe it out as we know it. The British Empire was very fond of doing this to any native culture it happened upon. The consequences weren't usually so wonderful for the heathens, and as a result the world lost much of its colour.

In part I, under "Purposes of Act," clause (d), it states that the act intends "to simplify and improve access to a continuum of community services by providing a framework for the development of multiservice agencies."

The government seems to believe the solution to the problem of a confusing, difficult-to-access system of community health care is an MSA. We agree that there could be some improvement in the present system but suggest that improvements could easily be made with additional technologies to the current structure.

At the present time, home care is woefully behind the rest of the world in its system of operations. We plod along under the weight of paper-oriented information systems, and in our office the fax is still a novelty. I personally remember that it was only three short years ago when I shared a black dial phone with another case manager. There was one phone line and you waited for it.

Improvements such as 1-800 numbers to provide a direct entry into the system, computerization and a common database for related agencies are tools that would greatly assist in achieving a "simplified and improved access" to services. Spending a few dollars in advertising and educating the population about community health services and how to call for help would simplify access. In our office, we get regular calls from people asking how much two-by-fours cost, or do we sell plumbing supplies, because they think the number in the phone book under "home care" means Home Care Hardware. Clients constantly tell me that before they needed home care services, they never knew they even existed. What a shame that the government has been paying for such a wonderful service and they don't even get much credit for it because of the lack of advertising.

Two other stated purposes of the act, clauses (c) and (f), which are "to recognize the importance of a person's needs and preferences in all aspects of the management and delivery of community services," and "to promote the efficient management of human, financial and other resources involved in the delivery of community services," are currently well addressed by the position of the case manager. The role of the case manager is one of direct service, though few recognize it as such because there is no laying on of hands and we are often just a voice at the other end of the phone line. But we individualize every plan of care for every client. We use a holistic approach. We access many other community services for people on the program, and especially for

people who do not qualify for the program. We have years and years of experience behind us that has taught us to listen to the client. Any plan of care is doomed to failure if it isn't tailored to their needs and desires.

At the same time that we advocate for our clients, we serve the government in allocating services in the most cost-effective way possible. It is really a remarkable concept when you think about it, but every square inch of Ontario is assigned to a real, live person, a case manager who will be responsible to assist in achieving the best possible outcome for the client. But what is even more remarkable is that Bill 173 doesn't even mention the words "case manager."

#### 1600

The first three stated purposes of Bill 173 are briefly as follows: "(a) to ensure that a wide range of community services are available...; (b) to improve the quality of community services...; (c) to recognize the importance of a person's needs and preferences...." We have serious doubts that the proposed structure of the MSA will promote these goals.

To explain, in the past we had only one nursing provider and one homemaking provider. When we had a case that required something unusual, the agency might say, "Sorry, we don't do evenings, or we don't do continuous infusion pumps," and the client did not receive the services he or she needed.

Then along came competition. There really is something to be said for it. A runner will never do his best time if he only races with himself. He needs someone to gauge himself against, to urge him to higher levels of achievement. Our business is no different. We need the competition in order to get more and better for our home care clients. Now that we have it, the government wants to remove it. The consumers will lose the quality and range of services, their right to choice will disappear and there will be little reason for the service providers to remain cost-effective.

We who work in the system have seen rapid change in the demands for more complicated procedures to be done in the home setting. This requires great skills and a willingness to be flexible, two attributes that we have seen grow in all of our agencies that we work with in the current environment of competition.

To further the discussion on improving the current system, we would ask the government's help. We need to be able to run our organization in a more businesslike manner. One essential element is that budgets have to be approved by the ministry before nine months have gone by into the fiscal year.

As well, the public has been told repeatedly that money cut from hospitals will flow into community care. The reality in our area is, our home care program has been capped. We continue to grow at a level of 18% but have been told there will be nothing to pay for that growth.

Not only do we need adequate money to pay for adequate services, we need the government to be open and honest with the public. They must know the truth about the real financial picture that we work with.

Consumers, hospital staff and even doctors have been led to believe that we are the rich kids on the block, and when they are told the reality, they vent their frustrations on us.

Other suggestions for improving the current system include increasing moneys to support services such as Meals on Wheels and friendly visiting programs.

Also, the duties and role of the homemaker, which translate into dollars to be spent, should be carefully examined. Some suggest removing housecleaning from the role of the homemaker. Homemaking skills have become quite sophisticated over the last years due to a demand from the system. Cleaning could be provided by the private sector while tax dollars are used for higher levels of care giving.

Another practical suggestion is for arbitrary and costly program divisions to be eliminated. Clients should be allowed to flow through the services they need as determined in conjunction with a case manager.

We have been told repeatedly of how this government has talked and listened to the public before drawing up this legislation. The flaw in this approach is that everyone is left wondering who it was exactly that they listened to. No one feels it was themselves who were heard. We certainly hope it's not too late for you to listen to the many presentations made to this committee and reconsider your approach in the reform of long-term care. We also hope that you will recognize the good in the present system and the wonderful skills of the people who currently work in it.

We have a system of community health care that is the envy of the world. To destabilize it, to turn the basket of services upside down, to create what might end up as mass unemployment or mass bumping of displaced hospital personnel into the unfamiliar territory of community health, to limit consumer choice would all be sad outcomes but very real possibilities.

To conclude, I would like you to listen to a statement from a colleague of mine who is not only a case manager but also a consumer of the home care program. Her experience as well as others' who have been on the receiving end tell us the greatest truths because they come from the heart. Thank you for your attention today.

**Mrs Lois Patchell:** Briefly, I would like to comment both as a case manager and as a consumer who has been there during the illness and death of my husband and again of my father. I might add that these two occurrences happened three hundred miles apart, so we are talking about service in more than one part of Ontario.

During the illness of my husband, the first nursing provider my husband was referred to was unable to provide the service that he required. His needs were more emotional than physical. He talked to his case manager about this as well as his concerns for his family. She in turn was able to provide another nursing service that was able to provide the palliative care he required. This is an option that is not readily apparent in the present legislation. She was also able to be more objective and to provide me with respite at a time when I was unable to recognize my own needs or the concerns my husband had

for me, and she did it without making me feel that I was not doing my job, not doing all I could.

As well, she was able to suggest appropriate services that I knew were there as a case manager but I forgot that they applied to me as a consumer. On the rare occasions that there were differences of opinions between service providers and my husband, he was able to talk to her about them without feeling he was reporting the individual to her supervisor, and he relied on the case manager's judgement to decide if the matter needed to be reported further.

Each of us here today is a consumer, either past or future. Many of us who have used the service in the past have found that except for a few minor areas that could be adjusted, we were in receipt of quality product. We hoped that this product could be preserved and enhanced with the least amount of disruption. When you or someone near you is experiencing a critical illness, you want the least amount of confusion and disruption. Families need someone to lean on and, if the length of illness is long, come to look on the primary service provider as a friend who should not be upset. For this reason, both my mother and I were happy to have the case manager as an approachable professional to provide us, with one phone call, someone to cope with our concerns.

Thank you very much for listening.

**1610**

**Ms Carter:** Thank you for your presentation. I'm really upset that you see this legislation as the colonizing power coming and upsetting the grass-roots civilization, as it were, because that's certainly not how we see it and how we want it to be. In fact, I have seen it put differently, that, as has been suggested here this afternoon, a lot of the services and agencies we have, have grown up because people on the spot could see the need and they cared and they made the effort and so the services were provided. This was—what shall I say?—something that happened spontaneously, but now we have the results of all that uncoordinated growth which maybe grew like Topsy and is better in some areas than in others. Now we need to take stock to look at the total picture to say: "Well, yes, some of this is great, but there are certain things missing. Some areas are served better than others."

We need to make sure that everybody in the province is getting at least minimum service. That is why we are looking at legislating and changing things and certainly there has been a big demand for change. To say that everybody is happy with things as they are is not true, and certainly this is something that we discovered when we went out and consulted with the public. That was genuine grass-roots consultation and there was feedback and we did change what we're doing as a result of that feedback.

We see this as evolution, as something that tries to bring existing agencies together and just coordinate things a little better. Certainly, case management is going to be a large part of what we envisage. People will be able to make this one call to access services instead of having to think: "Well, who do I need? Where should I call? What's the number?" People's needs will be assessed. Obviously, case managers have a large part in the

assessment and in the ongoing process and I see them coming into their own, as it were, having an even greater role to play than now.

I was quite upset where you said the money is not there as regards home services. I just wonder if we could have a little bit of enlightenment on that topic, maybe about the inclusion of case management and the financing of home support services.

**Mr Wessenger:** I think what you're asking is, what has happened with respect to the financing of community care? There certainly have been, overall, more moneys going into the system. There was a presentation today that was given to all committee members about what moneys have been invested in the system and what will be invested in the system.

I think the concern raised by the presenter is the aspect that some home care programs have been capped in some parts of the province, and Mr Quirt perhaps can give the basis on which that is done, but that sort of indicates what we're trying to do here. We're in a situation where basically we have limited financial resources and we have to deliver our services in a more cost-effective manner which puts more emphasis on the front-line delivery of services. We have to look at ways of rendering more efficient the administrative structure that delivers that service. At the same time, we have to look at a system that serves the consumer best.

I note there was an interesting presentation from, interesting enough, a home care director from Oxford, if I remember correctly, who set out what she thought were the advantages of having a system that was functionally integrated and also having, of course, a system that is responsive to the community. That's certainly the basis on which we're bringing this program, but I'll ask Mr Quirt on the specific matter of the financing.

**The Chair:** If you could just comment briefly and then I'll go back to our presenters.

**Mr Quirt:** In terms of the \$441-million investment in the long-term redirection budget, by the end of this year about \$250 million will be invested and there'll be \$190 million extra coming in the next two fiscal years.

The home care program itself grew by about 13% last year. We expect it to grow about 8% this year, and helping us manage that growth is a committee we have established with the Ontario Home Care Programs Association where we're looking at trying to match the growth across the province so that those areas with relatively less community services receive more growth than those programs that are relatively well resourced by comparison.

At one end of the spectrum, for example, one community can have five times as much spent on community services and long-term care as another community. So it's that inequity that we're trying to address by providing the money in accordance with an envelope funding system that tries to measure the requirement for community-based funding on the basis of population and age and so on.

**The Chair:** One last comment.

**Mrs Patchell:** I appreciate what you're saying about the growth and about the inequity across the country. I

even recognize inequity among our own program because we do cover both a rural and an urban area. We already have had 11% to 18% growth in our program this year and with the capped budget we are therefore unable to provide the kind of service that we're being asked for.

In addition, that's growth. It's not saying anything about the type of care that we're being asked to present, which is becoming more and more complex each day. I think this is something we do need to recognize when we're looking at this bill.

**The Chair:** Thank you both very much for coming before the committee today. We appreciate it.

**Mrs Sullivan:** Point of order, Mr Chair: I think I have heard Mr Quirt speak about the increase in home care financing for the second time. We received today a document indicating where the \$647 million was supposedly going. Could we have a further breakdown of the home care spending? Virtually every group we have heard, and certainly in my own community, tells me there's no more home care money and indeed their budgets have been capped and they are not getting the additional flows that we continue to hear about in the committee.

**The Chair:** We'll work out getting that information.  
ALL-CARE HEALTH SERVICES

**The Chair:** If I could now call upon the representatives from the All-Care Health Services.

**Ms Georgina Thompson:** My name is Georgina Thompson. I want to thank you for allowing me to come here today.

I'm here today to address the committee with respect to the proposed structure of the MSA under the provisions of Bill 173. In particular, I want to speak of the negative effect of what I believe to be a completely irrational and unnecessary provision in the bill. This is the provision which restricts to a maximum of 20% the amount of home care services that can be provided by so-called commercial, and not approved, not-for-profit agencies. This provision will simply erode everything from community health care services to services provided in group homes.

I would first like to take a brief moment to give you some background on myself as a small business person with a strong interest in the welfare of my community. I have included as an attachment to my material a copy of my CV.

It will probably be said that in making this presentation, I am simply trying to look after my own self-interest, and in a couple of senses that's true. Certainly, as one who started a health care service some 13 years ago, I'm despondent, to say the least, about the proposed exploitation of something I've worked very hard to create. But my interest is also that of the welfare of the community and of the consumers we look after as well as the dedicated staff that I work with.

In 1979, I graduated from a nursing program and worked three years at a local hospital. It was during that time, in 1981, that I left the hospital because of a need that I saw in our community, a gap in services. I started a health care service in the living room of my home. I

started this enterprise because there were clear gaps in the health care system in our community.

While working at our local hospital, I came to realize there were no home nursing or homemaking services in our community that were prepared to offer services on a 24-hour-a-day, seven-day-a-week basis. As a result, there were many people who wanted to go home from hospital, and in some instances simply to die in dignity at their own home, but couldn't do so because of the lack of service. So I made services available not only around the clock, seven days a week, but also in remote areas others were reluctant to serve.

Now I have a clear impression from the bill and from pronouncements from the Minister of Health that in earning a salary and in maintaining a responsible and viable service I am doing something that is morally wrong and that I'm stealing health care dollars. I ask the committee, how can this be, when I receive from the home care program the same amount per hour as a not-for-profit agency for homemaking services, and for visiting nursing services in Hastings and Prince Edward county I receive a lesser amount than not-for-profit colleagues, which have resulted in a saving to the province of over \$900,000, approximately, in the three and a half years we have been sharing this service.

I find it very difficult to accept, and I think every one of you would too, that I have taken the initiative to provide a much-needed service to the community and at the same time to earn a living and I am now confronted with the expiration of my business. I created jobs for over 450 people, almost all of whom are women, and in the case of many of our homemakers or home support workers these are people who do not have the educational background to be able to get many of the jobs that are out there now. For many of these people, I have not only created jobs but I have provided the means by which they can improve their knowledge and skills and certainly raise the level of their self-esteem, and now I'm being asked to turn that over to the government.

1620

I would also add that I have every reason to believe that the services I provide are well respected, not just in the communities we serve but also in the Ministry of Health. Two years ago, representatives of the ministry did a study of the three agencies in Prince Edward county and found no shortcomings in the scope and quality of services.

We have worked very hard for the past 13 years—and when I say “we” I'm including a staff of whom I'm very proud—to provide a quality service to the home care program which is not only efficient but cost-effective and innovative. In conjunction with people in the home care program, I've assisted in identifying gaps or inconsistencies in our programs. The existing structure for home care services isn't perfect and there are improvements that can be made, but this does not require the destruction of the system and the creation of another bureaucratic empire, with all that entails.

Over the past few years, I participated along with other providers in many meetings with home care personnel to discuss needs in the existing programs. There are gaps to

be filled, and I think we all agree that a single access point for consumers makes sense for the services in the community.

But why not provide these services through the existing structure of the home care program in its 38 province-wide sites? If the government wishes to have more community involvement, there seems to me to be no reason why each of these sites couldn't be governed by a local board of directors responsible to the ministry.

But why add to a single-access referral service the near-exclusive, direct provision of services that are already being provided effectively by a mix of not-for-profit and commercial agencies? For many in the not-for-profit sector, and I know this from my personal experience, volunteerism and its tremendous contributions to our society will be at best eroded significantly and at worst destroyed. Those agencies that are folded into the MSA will lose their identity, despite the contrary views that have been expressed, and that loss of identity will be accompanied by the loss of thousands and thousands of volunteer hours, not just in providing services but in the raising of millions of dollars in volunteer contributions. I'm sure you've heard this before, but don't be deluded: The folding into MSAs of not-for-profit organizations will destroy volunteerism in those agencies.

And why eliminate the competition factor that exists in the present brokerage model? As you know, this was done in Manitoba with unfortunate results. Competition is perhaps the most important factor in ensuring that there's quality and effectiveness in the provision of services. The absence of competition, which is what the proposed structure of the MSA will create, has brought many foreign states to their economic knees. Surely we should have learned from their ill-founded ideologies.

And why destroy the so-called commercial sector? On the one hand, government is saying it supports small business. But through the creation of the proposed MSA and the virtual elimination of the brokerage model, a significant element in the small business sector will be destroyed, and destroyed without any form of compensation, and its destruction will mean that consumers will lose the right of choice that is now available in the selection of a provider of home care and other services. Is this in the interests of the consumer?

What about the displacement of thousands of qualified workers and the loss of choice they now have in the selection of the organization with which they will work? Certainly this is not in their interest, nor is it in the interests of the consumer.

Ladies and gentlemen, there's much more I could say, but in the interests of letting you get on with your job, let me simply urge you, and through you the government, to:

—Create a centralized referral service, but utilize the existing home care program structure for this purpose.

—Don't abandon the existing brokerage model. It's a good model that embraces competition, and competition is the assurance for quality and cost-effective service provision. Combining a referral service with the direct provision of service in MSAs will serve only to create a costly and inefficient bureaucratic nightmare.

—Don't destroy volunteerism and its tremendous social and economic contribution to this province.

—Finally, don't for purely ideological reasons destroy the small businesses that are providing services, like agencies like mine. We have met and will continue to meet unfilled needs 24 hours a day, seven days a week, regardless of inconvenience of place. That has been an effective force in ensuring quality service, not just because of our dedication to quality service but because of the competitive influence we bring to the system, and that has not cost the ministry a single extra cent and that, in my instance, has and would continue to save the province's taxpayers many millions of dollars.

Thank you very much and I will be pleased to try and answer any of your questions.

**Mrs Sullivan:** I appreciate your presentation and the work that you've done, not only in health care but in other venues in the community that show in fact that even a commercial entrepreneur can be an involved citizen as well, and that's precisely the area I want to discuss with you.

In the hearings previously we have heard that the Ministry of Health has agreed to pay severances to those personnel from agencies who will no longer be able to stay in business, to the VON, to Red Cross and so on. They have not at this point made a public commitment to paying for assets that would be no longer used by those agencies when a new MSA came in, but I'm wondering if you would comment on the kind of policy approach the ministry is taking that says it will be prepared to pay for severances and possibly other costs. You've talked about expropriation. This is not an expropriation, because it appears to me that you wouldn't be compensated for the loss of your business. Would you comment on the kind of approach and the rationale, or the lack of rationality, in paying severances and other dislocation costs—it may be pension plans, it may be wage parity issues—that are involved, instead of putting that money into service provision?

**Ms Thompson:** To me, that's a waste of money, and I hope I answer your question. If not, you could correct me on it. I don't want compensation from the government to provide this service. I came out in this community because I saw a need for the service that I had to provide, and I don't see the forming of an MSA as being able to fill the gaps any better than what we're doing out here right now. If anything, it's going to be worse and confusing.

I don't want their money. I want to continue to provide a good, competent health care service in this community. My staff want to continue to work where we're working and provide that service. To take that money and spend it, to pay me off, to pay my staff off, when you can pay for the care that that consumer needs, the care that all of us are talking about here, 24-hour care, the care that people need to go home with an IV—the money that home care needs to do that kind of service, take the money and do that with it. Don't pay me off.

**Mrs Sullivan:** Thank you. I don't need to ask any more questions.

**The Chair:** Thank you very much for your presentation and for coming before the committee this afternoon.

1630

CANADIAN RED CROSS SOCIETY,  
ONTARIO DIVISION: QUINTE BRANCH;  
KINGSTON AND DISTRICT BRANCH

**The Chair:** I call on the representatives from the Canadian Red Cross Society, Quinte branch. Good afternoon. I want to thank you for coming to the committee today. We have a copy of your submission, so if you'd just introduce yourselves, then please go ahead.

**Ms Kay Summers:** Mr Chair and members of the standing committee on social development on Bill 173, I wish I could address each of you by name here today.

**Mr Villeneuve:** Go ahead.

**Ms Summers:** I'd love to, but I'm afraid that's just not possible. And may I use this as a first-class example of what I think the results of Bill 173 may be if it's implemented without some major changes.

Supporting me today in my presentation I have Barbara Floyd, from Belleville, and Marilyn Connors, from Kingston. As well, we are supported by some Red Cross volunteers and a number of Red Cross staff people.

I'm Kay Summers. I'm president of the Quinte branch of the Canadian Red Cross Society. I would like to address you today about how I see the role of the Red Cross, the Red Cross homemakers and the Red Cross volunteers in our community.

In our community locally, our profile is very high. For example, March is Red Cross Month, and our Red Cross flag flies high over city hall during all of that month. We have a very high profile with United Way and in other parts of our community. We've had a sold-out fashion show as a money-raiser, and we're already planning for another high-profile community money-raising event in the future. We're hoping to have Big Ben's footprint on that contract.

**Mr Villeneuve:** He's retired.

**Ms Summers:** Yes, but we're going to use him as a money-maker for Red Cross and we've already made our initial contact with Big Ben. Glad to know you know who Big Ben is there. It's not London.

Public awareness at the local level is very high. My reason for emphasizing this is in relation to the volunteers. High profile locally; high response from volunteers. Therefore, to take away the Red Cross local connection and replace it with a government-run homemaker program, you immediately lose the profile and you will lose the volunteers.

Clients like to relate to their care givers, and they do relate to the Red Cross homemaker. The clients trust us and they want Red Cross homemakers to still be there for them.

At present, the Red Cross home support service has a core of 10,000 volunteers and a staff of almost 6,000, the majority of whom are women. Do you think this core of 10,000 volunteers will transfer their loyalty and their support to a provincially run organization? I do not. Mr Wilson, I believe in Simcoe county you have 1,000 Red

Cross volunteers. I don't think they'd transfer their support.

We, a taxpaying population, need to keep as many organizations volunteer-based as possible. We cannot afford to pay for all the services volunteers are now doing, and this relates not only to home support and homemaking but to all health and community services. You have to keep a strong volunteer base, and to do that you must keep the volunteers connected with an organization that they trust and relate to, the Canadian Red Cross branches.

The Red Cross wants to remain a part of long-term care. Based on our fundamental principles, we must maintain our identity and independence. Bill 173 must be changed to allow this to happen.

**Ms Barbara Floyd:** I am Barbara Floyd. I'm the volunteer chair of the Quinte homemaker branch. I like to call myself the voice for homemakers throughout Hastings and Prince Edward.

There have been many presentations to this standing committee on social development on behalf of the Canadian Red Cross Society, and I would like to provide for you further insight about Red Cross homemakers from my own experience, an explanation of some of the Canadian Red Cross involvement in the long-term care development process and the assistance which has been provided in the analysis of ministry documents—and, as we all know, those have been many—and, thirdly, a reaffirmation of points for your consideration.

I'd like to give you a little bit of my background, as other speakers have said they included their CV. I didn't, but I think wearing this many hats has made me very, very interested in this whole process. My background is as a home economist-nutritionist, and I was involved in gerontology both at the university and college level in Toronto. This led me to volunteer as chairperson, and I've been that chairperson for six years. I'm also the Ontario east-central representative to the Red Cross. Therefore, I attend the Ontario division homemaker services committee, and at those meetings I've heard so much about what's happening in long-term care all across the province. I have been actively involved for the last year and a half as a south Hastings provider representative on the Hastings and Prince Edward long-term care committee. I also chair the seniors' subcommittee, and that subcommittee—any of the subcommittees—study the long-term care issues from the different population group perspectives, and then we report to the long-term care committee.

However, today we will focus our remarks on the services that as Red Cross we provide in the areas of Simcoe, Muskoka, Haliburton, Victoria, Peterborough, Northumberland, Hastings, Prince Edward, Lennox-Addington, Frontenac, Kingston, Lanark, Leeds and Grenville. We've heard from many areas like that today.

In this geographical area, the Canadian Red Cross Society employs approximately 1,500 homemakers, providing almost 1.3 million hours of service to 18,000 clients this year. The support staff is made up of 80 full-time equivalent positions.

From my experience when I first joined Quinte and went to the in-service meetings that the homemakers attend, one of my first comments was, "I can't tell you how I felt being with 100 very warm and caring women." It was a marvellous feeling, and that can only be created by the supervisors and the clerks in the office. They help to create that atmosphere, as they often go the extra mile in serving our clients and assisting the homemakers in providing a high quality of service.

I thought of an example to give you of the responsiveness. We had a weekend client. On the Saturday morning, the homemaker called in and said she was ill. We have a supervisor on call, who had to find another homemaker in that same geographic area, and as you know, we go from Lake Ontario to Algonquin Park, so one has to consider mileage etc. After a number of phone calls, yes, we found a homemaker who happened to be on a visit with her parents but, yes, indeed she would go and fulfil that role. They are certainly to be admired.

For 75 years, the homemakers have been ambassadors for the Red Cross for all its programs throughout all the areas served in Ontario.

Now, thinking of the time—and I know you people have been here all day—I thought perhaps we would just move on. You can read section 2. The point I was trying to make there was that I wanted to emphasize the geographic challenge as well as the way we have tried to work, the interrelationship between Red Cross, the long-term care committee, the local branches, the province, and the fact that we've been meeting with other providers throughout Hastings and Prince Edward.

My final statement under that section 2 is that the challenge has been to understand the needs of the client, the diversity of existing personnel and services and to combine the expertise and goals of the provider agencies, including the Canadian Red Cross Society, with the long-term care plans of the ministry. I would really like to know if there aren't ways by which Red Cross services could stay in this long-term care system. So I thought of that, and the factors I felt were important for this committee to address and to think about and hopefully relate to some of the information which I've included. The first had been mentioned often before, flexibility.

The legislation and the regulations need to be flexible for the individual communities to design a system that fits and responds to the needs of the community. For example, as the system is presently structured, homemaker service is funded on an hourly basis. If the funding envelope could allow for block funding, the hands-on provider would be better able to decide with the client on how to address their needs.

#### 1640

I'm referring to this, which was the cover of the presentation that you received, and in the second recommendation there, which is on the second half of fact sheet 1, ask that the legislation be reworded to remove limits on the amount of service that an MSA may purchase. This allows each community to determine the best mix of services available for its citizens.

Our third recommendation there is that it would

provide communities with the time they require to create a design that best suits their needs.

After flexibility, I'd like you to consider the human and economic resources. Greater consideration needs to be given to the effect on the workers and the cost of facility and equipment changes in what Douglas Jackson, from the office of the special advisor on MSAs, sent out on August 22, calls "the integration of existing services." For instance, some changes may take longer than the four years allowed in the legislation, but perhaps some of the interim models that are set up could even be made permanent. There must be wise use made of all resources.

The complex task of long-term care reform has been under way for many years. So many principles of the reform are widely supported by the Canadian Red Cross. In committees, we've discussed the strengths and weaknesses of our present system. As an aside, I was intrigued when Community Support mentioned its list; we were in on that discussion. So you've already heard part of that. As we continue to meet throughout Hastings and Prince Edward counties, suggestions will be made as to how to implement one-stop access, information sharing, delivery etc. We look forward to being a participating partner in the delivery of long-term care services as part of the reform process. However, as has been said so often before, as Bill 173 is presently drafted, the Canadian Red Cross Society would be excluded.

Presenters for Red Cross across the province have identified a number of initiatives that would increase the efficiency and effectiveness of service provision. I have added my thoughts on factors that should be considered. The Canadian Red Cross volunteers and staff are willing to assist and to discuss ways of implementing our proposed suggestions for change. The Canadian Red Cross Society wants to continue to participate in the planning and to be part of the long-term care service delivery. Marilyn?

**Ms Marilyn Connors:** Hi, everybody. My name is Marilyn Connors. I'm a Red Cross volunteer and a member of the Kingston and district branch homemaker advisory committee.

I would like to briefly outline some insights into service provision in the surrounding areas. In the Kingston area, the Canadian Red Cross Society has been a vital element since 1900. At a recent district health council consultation, participants were heard to say that they want community agencies to continue to exist and to be part of the long-term care system. It has also been clearly identified in this community that choice of service provider is important to the consumer. In Kingston, the Canadian Red Cross has provided leadership, initiating community discussion and planning for enhancements in access and coordination of services.

The Kingston district includes a large rural area. This presents an ongoing challenge to service provision. In this district, we experience an ongoing deficit because of the significant cost of travel in our rural areas and to the three islands that we service. The Red Cross made a provincial decision to provide payment to homemakers for transportation costs. As well, in keeping with our fundamental principles and mission, we provide services

where help is needed, not just where it is cost-efficient.

Homemaker service has been provided in Lanark, Leeds and Grenville since 1961. Currently, we are working towards collaborating with other service providers, including home care, VON, home support services and attendant care, in an effort to improve access and enhance the services to our communities. One of these initiatives is a shared care project within a non-profit housing complex. Shared care increases flexibility and is more cost-effective. Through the use of a team of homemakers, fewer homemakers are able to provide services to the same number of clients by streamlining the duties. Also, we have embarked on discussions to reduce duplication of case management of integrated homemaker program clients. This will improve coordination of service to the client and reduce costs.

In the Brockville area, key providers have been working together for several years to improve community services. Our accomplishments include a generic home chart, streamlined assessments and community-wide protocols for caring for clients with AIDS and DNR.

In conclusion, the Canadian Red Cross Society is proud of its homemaker and home support services. The Ontario division genuinely hopes that changes brought about by long-term care reform will not preclude us from continuing our over 75 years of providing services to our communities. Through our comprehensive range of programs, we are fulfilling our mandate to support the frail and vulnerable, enabling them to live with dignity and as independently as possible in their homes.

We are also proud of the Canadian Red Cross's contribution to the professionalization of the role of the homemaker. This occupation, primarily filled by women, continues to evolve. We are the largest employer of homemakers in the province. We are committed to continue to provide leadership to the industry, setting standards through our comprehensive provincial programs for quality management and risk prevention and our educational programs and resources.

The Red Cross is ready to play a constructive role in the future of community-based services within Ontario. We have demonstrated our willingness to cooperate with other providers to improve services in our communities. We have identified a number of initiatives that we feel would increase the efficiency and effectiveness of service provision and are willing to provide leadership in implementing these changes. We sincerely hope that the legislation can be amended to allow us to continue to provide home support services and homemaking to the people of Ontario.

**Mr Jim Wilson:** Thank you very much for your presentation. This being near the end of the second-last day of hearings, this may in fact be the last time in the history of Ontario that the area of the Canadian Red Cross that you represent will be making a presentation outside of Metropolitan Toronto, because you may not exist when this legislation comes into place. I'm very cognizant of that, as are my colleagues.

Kay, I thank you for reminding me and in fact Mr Wessinger, the parliamentary assistant to the Minister of Health, who also represents Simcoe county, that we have

1,000 volunteers. I think, Paul, that most of them are in my area, because, as you know, we both attend their volunteer appreciation luncheons each year and say thank you to them on behalf of local residents and the province. I hand out pins to the ones who actually live in my area, and I think last year I gave out close to 600 pins to people to show our appreciation. I didn't know this was coming down the pipeline. Had I known, I might have taken the opportunity to get a grass-roots demonstration going or something.

With this bill, I'm not sure how much hope there is that the government is going to change its mind. Things that you mention, like the 80-20 rule, as far as I can tell, the government thinks that's key. It's certainly driving the private sector out of business; they did it in day care. That's key to them, and I can't see them changing their minds on that. We are going to try, and we're going to introduce amendments.

How we deal with volunteers and the loss of volunteerism that will result from this bill: I think the evidence is overwhelming in the three weeks of public hearings that MSAs will not be structured, according to this legislation, so that they can retain the individual identities and the heart and soul of all those agencies.

#### 1650

Red Cross has made it very clear to us, at all levels of the Red Cross, that the corporate structure of the Red Cross does not allow it to become part of the MSA. So on that front, how will the services in the areas you represent possibly be replaced if Red Cross and commercial agencies and other not-for-profit agencies are simply driven out of the delivery of home support and home-making services? How are the people going to receive those services if Red Cross doesn't blink? I wonder if the government is playing a bit of a game here. Do they want Red Cross to change its corporate structure, to buy into the MSA? Who's going to blink?

It's a very dangerous game, because I just can't picture how in the world government is going to replace all the services and the volunteers and the dollars and the fundraising dollars that you people represent. So you tell me what they tell you in response to that, and I'll judge whether it's credible or not from the government's point of view.

**Ms Floyd:** I'm not sure I exactly know how to answer, if you want me to answer. I heard the VON presentation today. I'm now wearing my long-term-care hat. I don't know if any of you realize what a challenge it is to have sat in on all the long-term care deliberations and read all the documents and so on and have still said to myself: "Please, we've got some great Red Cross homemakers. How can we keep them in business?" Can I go to a Red Cross homemaker meeting and try and explain it to them? That's a tremendous challenge that I haven't honestly faced yet.

I wondered—I don't wonder, I wish that more serious consideration could be given to an integrated model so indeed—with some legalese that I'm not quite familiar with in the Corporations Act, and the fact that Red Cross is incorporated, there are other people in the room who probably can answer this a little more clearly than I

can—the Red Cross and our other provider agencies would be able to at least receive some block funding and continue to provide the service. Does that answer a little bit of what you're hoping that we might be thinking about? Can I take it another step with the long-term care?

**Mr Jim Wilson:** Sure.

**Ms Floyd:** I know from the deliberations that we are holding—we are going to now have six or seven meetings throughout Hastings and Prince Edward, Belleville, Bancroft, Picton and so on—we want the grass-roots input. Knowing our homemakers and being a bit of a care giver myself, I know what some of that input is going to be. They want the service locally, as it's now provided.

Are there not some ways that our community support agencies can also still maintain some of their identity and allow those volunteers, as we keep calling them, to be able to identify more closely? If you've got somebody who's a transportation person who lives on rural route 8, and so and so needs a ride, can't that person still be the one who's going to provide that transportation? Those kinds of things.

**Mr Jim Wilson:** Well, all I can assure you is that we're going to do everything we can, and we've already talked to legislative counsel—not the one represented here but the ones that work for members at Queen's Park—to try and see what we can do in a technical way with the bill to ensure that Red Cross can be part of the MSA. I don't know how you preserve individual identity.

You mentioned Simcoe county. We've gone through municipal government amalgamations with regional government, essentially, now. When you amalgamate places or integrate them or whatever bureaucratise you want to use in this day and age, they lose their identity. There are many places in regions in Ontario, again using the municipal model, that simply don't exist any more. I think of Galt; the sign is not up any more.

**Mr Conway:** There should be a state trial for that man, Darcy McKeough.

**Mr Jim Wilson:** All three governments have gone through this. We just fail to learn, and I think people are fed up. I think, and perhaps you'll back me on this, when you get out there and you go to those meetings that you're talking about, all hell will break out with people. There is no way I can picture that the 1,000 volunteers in Simcoe county are going to let Mr Wessinger away with bumping the Red Cross or me away with having any part of it—and I'm trying to do everything to prevent it—or the government away with bumping the Red Cross and the VON and everybody else out of business. When people get word of this bill, all hell is going to break out in this province. I think Mr Conway was alluding to that earlier. Do you think we're going to see, finally, the people say, "I've had enough of this stuff"?

**Ms Floyd:** At this point, I don't think they even realize what's happening. I do a lot of talking, and even with my own bridge-playing friends I try to say, "Do you realize how this is going to affect you?" We've got such a big advertising job to do. Who is going to do it? We don't want to promote our own demise.

**The Chair:** I'm sorry that I have to jump in. We have

one more presenter, and then I'm afraid we have to get to the railway station. On behalf of the committee, I thank the three of you for coming before us and making your presentation this afternoon.

**Ms Floyd:** Thank you very much for your time, and I wish you well in your deliberations.

MARIE FLOOD

**The Chair:** I call upon our final presenter, Marie Flood. Mrs Flood, thank you very much for coming before the committee this afternoon.

**Mrs Marie Flood:** First off, ladies and gentlemen, thank you, all of you, because I'm one of the ones you have helped, and I totally agree with everything that you've said here today. They are not going to get away with this.

**The Chair:** Mrs Flood, could I just ask you—because of the Hansard reporting, that might not have been recorded.

**Mrs Flood:** Yes, sir.

**Mr Conway:** People call him Charlie.

**Mrs Flood:** Charlie. My name is Marie Flood. I live in a small farming community called Plum Hollow. I'm the mother of six adults, and I've eight grandchildren. I do not belong to any organization that these people here belong to. I have been a homemaker and a care giver for 39 years in my own home.

In 1981, my husband, Bernard Flood, took ill, and over the next 13 years I was the prime care giver. On July 31 of this year, Bernard passed away in our home, with lung and brain cancer. In one year, I watched my husband go from a 201-pound man to less than 80 pounds, with a lace of skin over his bones. I'm here today to speak on behalf of my husband, my friends and my neighbours.

We need changes in our health care in the farming community. The VONs, the Red Cross homemakers and the home care are our lifeline to the outside world when we have someone who is housebound. These girls are handicapped by rules that don't apply out in the country; they might work well when you live in a city or a town.

I did not know about this piece of paper. I was just handed it just a little while ago. I didn't realize that you were trying to get rid of the Red Cross homemakers, you were trying to get rid of our VONs and you were trying to get rid of our homemakers. I'm furious. I'm just furious to think that you would do such a thing.

1700

We need changes, but we don't need the type of changes that you're going for. We need nursing practitioners out in the country. This would be an asset to our VONs. We need better access to medications such as heroin and morphine for cancer patients. We need our VONs so that they can sign a death certificate instead of waiting six hours for a doctor to come to our homes, and maybe even a little bit longer than that, because, you see, doctors who live in the city don't like to come out on holiday weekends. If your husband or a loved one dies at 12 o'clock at night, they expect you to keep that loved one there in the home until 6 o'clock in the morning.

Red Cross homemakers: I don't know what I would

have done without them. They chased me out of the house when I wanted to stay. I don't know if any of you have ever been in the position that I have been in, but they give you a sense of being. They're there to give you that little extra push you need to go to town. That's fine for people in the city; they can just get in their cars or they can get on a bus and go to town, but people in government forget that the ones of us out in the country have to travel a long way to get to town. My nearest town is 11 miles away. My nearest city is something like 35 miles away. So if I go to town and a Red Cross homemaker cannot give my husband his medication, it means that if I leave at 1, I have to be back at 2 to give him his medication, because the law says that the Red Cross homemaker is not allowed to give out meds now. These girls are trained for this, but this has been taken away from them.

We need paramedics in the country. You don't need them in downtown Ottawa or downtown Toronto. My, you've got hospitals all over the place. We need them here. We need our ambulance drivers and our firemen to be trained as paramedics. We need more places for helicopters to land to take farmers or their children who have been hurt by machinery into town, into big hospitals like Ottawa or Kingston for proper care.

I don't know whether you know this or not, but people out in the country are tied down to ambulances going to certain hospitals. At one time my husband was very ill in this past 13 years, and I had him home. I was told by our family doctor that if he took sick during the night, instead of calling the ambulance to my house, to put my husband in the car, drive him as far as Seeleys Bay, and the Seeleys Bay ambulance would then take him to the hospital that he needed to go to, where his records were. You see, where I live, if I call an ambulance, they would come to my house, but first off they would take him to Brockville and then they would transfer him into Kingston, which was a waste of time. When my husband needed care, he needed it that minute. He didn't need it three or four hours from then.

These are things that city people don't think of. Our medical centres out in the country I would like under some kind of a blanket coverage where they all work the same, so that they can interact. We have doctors out in the country who don't have privileges at certain hospitals. This does not do country people any good. It just doesn't work. I mean, if we're in one part of Leeds-Grenville—

The system isn't working for us; it just isn't. Sickness doesn't stop at 4:30 on Friday afternoon. If any of you have children, you know that, or if you have sick loved ones. We need better access to medical care on the weekends. If Bernard had lived the day of the 31st, our VON would have had to travel for 40 minutes to pick up vials of morphine at the psych hospital in Brockville, because there were none available anywhere out our way, not in any drugstore. Things like this have to be looked into.

Doctors do not prescribe heroin for cancer patients because they might become addicted. When you're told this 11 days before your husband dies, there's another thing that's wrong with our health system. There's

something wrong. It's just not right.

My own feelings? I'm going to work with Svend Robinson now and I am going to fight for euthanasia. I don't want another human being going through what my husband went through. I think common sense has left and education has taken over. I was raised that if you used common sense and you used your education as a tool, you would end your life in good shape. I think a lot of you, if you stopped and used your common sense, you would do a lot better.

If you want the ones of us who are looking after our sick people, our sick loved ones, to do it at home, then you leave our VONs, our Red Cross homemakers and our home care alone, because I'm telling you, if we have a change and we don't have women or men coming to our homes whom we know and we trust, you are going to have the biggest uprising that you have ever seen, and I will start it. I'm not threatening—yes, I am threatening. Yes, I am, because I'm that mad. If you want us to keep them at home and you don't want them going to the hospital, leave our services alone.

I'd like to thank you very much.

**Mr Martin:** I want to thank you very much. You certainly tell a compelling story. I guess I couldn't think of any more effective way of painting the picture that we as a government look at as we try to get our heads around how we better deliver services to all of the people who live in every corner of this province.

You've obviously pointed to some areas of some very real concern, areas where there are shortcomings, where there needs to be enhancement of program delivery. In fact, believe me or not, that's what this piece of legislation is about.

I would ask you, Mrs Flood—

**Mrs Flood:** I don't think so.

**Mr Martin:** —to be wary of those who would tell you differently, be wary of those—

**Mrs Flood:** No.

**Mr Martin:** —who have agendas of self-preservation as opposed to—

**Mrs Flood:** I'm not listening to anybody with self-preservation.

**Mr Martin:** —an agenda of trying to better the services that we now have, that are in themselves very good but are not in many instances adequate.

I'm a politician. I'm a part of this government. I'm a son of two elderly parents who are dependent on home care. I know the commitment of the people out there who work for Red Cross and the VON. They will not be turfed out or left out of the equation. In the end, if local people under the guise of the district health council and the long-term care planning committees that are formed by them, members as well who live in communities, decide that another organization that will be more coordinated and efficient is the one that will do the job best in that area, those people will work for that

organization and will continue to be as committed as they are now in the delivery of that program.

I guess the only question I would have of you, Mrs Flood, is, what is it that you see that we're doing re this piece of legislation that will in fact not do that?

**Mrs Flood:** I think you're wasting money. That's the biggest. I think that you really don't have any idea; you don't have a clue. Have you ever been to Princess Margaret Hospital? Have you ever been to Henderson hospital in Hamilton, Mac hospital? Have you ever been out in the country and walked into a living room that's been made into a hospital room?

**Mr Martin:** As a matter of fact, I come from Ireland, Mrs Flood, and we used to have wakes in the living rooms of homes, you know? So I understand that.

**Mrs Flood:** No. No.

**Mr Martin:** I understand the culture of that particular piece of—

**Mrs Flood:** You see, you have made up your mind. You have made up your mind what you're going to do. I have made up my mind what I'm going to do.

**Mr Martin:** I would hope, I guess, that it's based on the truth.

**Mrs Flood:** Common sense.

**Mr Martin:** And common sense, yes.

**Mrs Flood:** Common sense. That is the key word: common sense.

**Mr Martin:** And you would choose to work with your local district health council and planning agency as they grapple with the questions of how we improve the system so that everybody gets good service.

**Mrs Flood:** But we don't need—what do we need? What are you planning to give us that we don't have already except—

**Mr Martin:** Well, you listed a whole pile of shortcomings in your presentation.

**Mrs Flood:** Now I want to add a thing here. What are you going to give us except a telephone number, one telephone number that we can call? Here we are again: When you call a health system, you get an answering system that says, "If you will hold"—they don't tell you for 25 minutes—"you will be the next on the list to be answered." Then you get on to another telephone line and somebody else says, "We're sorry, but we have nobody available right now, but if you will hold..." You're telling me that you're going to have enough people on the end of those lines to look after our needs?

**The Chair:** I think you've made your point very clear. At this point, Mrs Flood, on behalf of the committee I thank you for coming and making your presentation at the end of our hearings here in Kingston.

If members would just remember, please: Tomorrow morning, 9 o'clock, we begin our hearings again in Toronto.

*The committee adjourned at 1713.*

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York-Mackenzie L)
- Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- \***Acting Chair / Président suppléant:** McGuinty, Dalton (Ottawa South/-Sud L)
- \*Carter, Jenny (Peterborough ND)
- Cunningham, Dianne (London North/-Nord PC)
- Hope, Randy R. (Chatham-Kent ND)
- \*Martin, Tony (Sault Ste Marie ND)
- O'Connor, Larry (Durham-York ND)
- O'Neill, Yvonne (Ottawa-Rideau L)
- Owens, Stephen (Scarborough Centre ND)
- Rizzo, Tony (Oakwood ND)
- \*Wilson, Jim (Simcoe West/-Ouest PC)

\**In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

- Conway, Sean G. (Renfrew North/-Nord L) for Mrs O'Neill
- Johnson, Paul R. (Prince Edward-Lennox-South Hastings/ Prince Edward-Lennox-Hastings-Sud ND) for Mr O'Connor
- Malkowski, Gary (York East/-Est ND) for Mr Hope
- Sullivan, Barbara (Halton Centre L) for Mr Eddy
- Villeneuve, Noble (S-D-G & East Grenville/S-D-G & Grenville-Est PC) for Mrs Cunningham
- Wessinger, Paul (Simcoe Centre ND) for Mr Owens
- Wilson, Gary, (Kingston and The Islands/Kingston et Les Îles ND) for Mr Rizzo

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

- Quirt, Geoff, acting executive director, long-term care division
- Wessinger, Paul, parliamentary assistant to the minister

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Boucher, Joanne, research officer, Legislative Research Service

# CONTENTS

Wednesday 14 September 1994

<b>Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,</b>	
projet de loi 173, <i>M<sup>me</sup> Grier</i> .....	S-2149
Joint Liaison Committee of the Academic Health Sciences Centre of Southeastern Ontario .....	S-2149
Paul Rosenbaum, director of planning and secretary	
Hastings and Prince Edward Counties District Health Council .....	S-2151
Alan Mathany, chair	
Barbara Jones, vice-chair, long-term care planning committee	
Jeanne Thomas, health care planner, long-term care	
Nightingale Nursing Registry Ltd .....	S-2155
Sally Mark, director of finance	
Association of Ontario Physicians and Dentists in Public Service, Kingston branch .....	S-2156
Dr Jane Baldock, executive secretary	
Peterborough County-City District Health Unit; Haliburton, Kawartha, Pine Ridge District Health Unit .....	S-2159
Debra Cooper Burger, supervisor of coordination, Peterborough County-City DHU	
Dr Alex Hukowich, medical officer of health, Haliburton, Kawartha, Pine Ridge DHU	
Kingston, Frontenac and Lennox and Addington Health Unit .....	S-2162
Alex Lampropoulos, board chair	
Dr David Mowat, medical officer of health and chief executive officer	
Providence Continuing Care Centre .....	S-2164
David Bonham, board chair	
Guy Legros, president and chief executive officer	
Sister Sheila Langton, administrator, Providence Manor and vice-president, east, Providence Health System	
Victorian Order of Nurses: Hastings, Northumberland, Prince Edward branch; Eastern Lake Ontario branch;	
Lanark branch; Brockville, Leeds and Grenville branch .....	S-2168
Penny Smiley, president, Eastern Lake Ontario branch	
Mary Lou Workman, president, Hastings, Northumberland, Prince Edward branch	
Kathy Robertson, president, Brockville, Leeds and Grenville branch	
Kingston, Frontenac and Lennox and Addington District Health Council .....	S-2172
Shirley Sedore, chair, long-term care committee	
Judith Mackenzie, senior planner	
Cheryl O'Connor, long-term care planner	
Ontario Community Support Association, areas 8 and 9 .....	S-2175
Elizabeth Fulford, board member, area 8	
Pat Dandelé, chair, area 9	
Rideau Valley District Health Council .....	S-2177
Peter McKenna, past president	
Peter Tudor-Roberts, executive director	
Norma O'Shea .....	S-2178
Hastings and Prince Edward Home Support Network .....	S-2181
Jeanne Goodhand, chair	
Haliburton, Kawartha and Pine Ridge District Health Council .....	S-2184
Barbara Moffat, chair	
Lesley Peterson, chair, long-term care committee, Northumberland county	
Royal Canadian Legion, Ontario Command .....	S-2186
Jim Margerum, chair, veteran services	
Leeds, Grenville and Lanark Home Care Program .....	S-2190
Connie Lendrum, home care case manager	
Lois Patchell, home care case manager	
All-Care Health Services .....	S-2193
Georgina Thompson, president	
Canadian Red Cross Society, Ontario division: Quinte branch; Kingston and district branch .....	S-2195
Kay Summers, president, Quinte branch	
Barbara Floyd, chair, homemaker services committee, Quinte branch	
Marilyn Connors, member, homemaker advisory committee, Kingston and district branch	
Marie Flood .....	S-2199



S-69

S-69

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Thursday 15 September 1994

# Journal des débats (Hansard)

Jeudi 15 septembre 1994

## Standing committee on social development

Long-Term Care Act, 1994

## Comité permanent des affaires sociales

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



*50th anniversary*

**1944–1994**

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Thursday 15 September 1994

Jeudi 15 septembre 1994

*The committee met at 0907 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS  
DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Chair (Mr Charles Beer):** Good morning, ladies and gentlemen. The standing committee on social development is now in session. For committee members who have been on the road, it's Thursday and we are back at Queen's Park. We are still examining Bill 173.

We have again a very long day of hearings. If I could at the outset, both for members' remembrance as well as for those who are with us today, I note that because we have wanted to ensure that we heard from as many presenters as possible, we have placed more emphasis on hearing from the presenters, and that means less time for questions. So the rotation will be as we have been doing, with one question per presenter, and we rotate that through the different caucuses. We'd like to have more time for questions, but the tradeoff was trying to make sure that we got people to make their presentations before the committee.

## WOODGREEN COMMUNITY CENTRE OF TORONTO

**The Chair:** I welcome our first presenters this morning, from WoodGreen Community Centre, if they would be good enough to come forward. We want to welcome you all to the committee. Perhaps you would be good enough just to introduce yourselves for the committee members and for Hansard. We have a copy of your presentation. Once you're settled, please go ahead.

**Mr Brian Smith:** Thank you very much, Mr Chairman, for the opportunity of addressing the committee on this important matter. My name is Brian Smith and I'm the president of WoodGreen Community Centre. I'd like to introduce Amy Go, who's the director of our senior services, and Margaret Bryce, who's a board member and a member of our seniors' advisory committee. I am going to start off with the presentation and Amy Go and Margaret will also present as part of our presentation.

WoodGreen Community Centre supports the principles of long-term care reform and believes the proposed Bill 173 is a concrete step towards implementing these principles. However, we are concerned that without certain amendments, the present legislation may become a barrier towards reaching the goals that are shared by both the government and the community; that is, to develop an MSA system that provides equitable, accessible and high-

quality services in a cost-effective and accountable manner.

WoodGreen has been a comprehensive multiservice agency in the Riverdale community of east Toronto since 1937. The organization provides child care, adult protection, mental health, immigrant employment, neighbourhood housing and seniors services to our community of over 80,000 individuals. WoodGreen's seniors unit provides home support programs, homemaking and IHP through Metro home care, supportive housing and three elderly persons' centres. These programs operate effectively in both English and Chinese, since over 20% of our community's first language is Chinese. Other than the nursing and physiotherapy services, WoodGreen provides almost all other services that are included in the MSA basket of services.

We have concerns that the criteria imposed by the planning process of the DHC will restrict not only the flexibility of the local delivery organizations but ultimately the flexibility of service provision to the individuals in our community who for cultural, economic or lifestyle reasons do not fit into a regimented and highly regulated service delivery system. WoodGreen is able to serve them now. Our concern is the ability for these individuals to continue to receive service in the future.

We urge you to ensure that this flexibility is maintained in the future and local planning bodies and ministry policy and operational structures are not able to regulate this flexibility out of existence.

I would like Amy to give you more concrete examples of what I've been mentioning.

**Ms Amy Go:** I'd like to share our concerns by illustrating an example of Mr and Mrs Wong's experience. They are a senior Chinese couple who live in Riverdale.

Mr Wong was recently admitted into a nursing home. His placement came after years of struggle by the family to keep him at home. A few years ago Mr Wong had two massive strokes which had weakened both sides of his body. As a result, he was incontinent, confused and frail. After discharge from the hospital, he was receiving three hours of daily nursing and homemaking services. His wife, the primary care giver, also suffered from a chronic disease that challenged her ability to continue in the care giver's role.

As Mr Wong's condition deteriorated, the stress on Mrs Wong, physically and emotionally, also escalated. Although Mr and Mrs Wong received a lot of support from their married daughter, unfortunately she was laid off from work and was emotionally and financially

devastated. In fact, their daughter had been caught in an abusive relationship in her own home and sought assistance from WoodGreen as well.

As a community centre that has been serving Riverdale for over 57 years, we come across situations like Mr Wong's on a daily basis. Other than providing a wide range of home support services to seniors and people with disabilities, we also work closely with families and other people in our community. The comprehensiveness of our scope enables us to provide support not only to Mr Wong and Mrs Wong, but also to other family members. However, we are concerned that the process the government has set up will fragment, if not eliminate, this comprehensive neighbourhood service. We believe the Wongs' needs, like those of many seniors and people with disabilities, should be addressed in a holistic and comprehensive manner.

Working closely with the family, our bilingual client intervention and assistance counsellor coordinated a wide range of services to address their physical needs. These included nursing services as well as homemaking, home help and meals on wheels provided by WoodGreen. It was also important for the counsellor to ensure that all these services are provided in a culturally appropriate manner. Mr Wong was also referred to our Chinese frail elderly day program, where he could participate in social and remedial activities.

To alleviate the emotional burden experienced by Mrs Wong, our counsellor spent a lot of time supporting her and her daughter. WoodGreen's immigrant services counsellor was also brought in to help their daughter apply for financial assistance and provide her with the support to confront the abuse. When Mr Wong's condition deteriorated, we coordinated his placement. Presently, we continue to provide home support services to Mrs Wong and counselling support to her and other family members.

Highlighted in the Wongs' experience is the need for government policies and legislation to appreciate the interconnectedness between the physical, emotional, mental and social needs of consumers. The policy framework, including the present proposed legislation, should ensure that WoodGreen and the future MSAs remain community focused, comprehensive, flexible, equitable, accessible and responsive.

Let us share with you the vision of WoodGreen with regard to Bill 173. We would like to see legislation that will empower the MSAs with adequate resources, support and flexibility so that changing community needs can be met without cumbersome bureaucratic approval.

The client intervention and assistance program is essential to this holistic approach and must be specifically identified in the legislation. Other than providing the wide range of health and social services, it is also very important for the MSA to adopt a preventive and wellness-centred approach in its operations. This includes community development strategies that enable the MSAs to work with consumers, care givers and other community members to address collective concerns in constantly working towards the betterment of the wellbeing for all. Anti-racism and anti-discrimination policies should govern the MSAs, together with very clear equity

measures in programming, human resources, governance structure and all other aspects.

Counter to this vision are the current provisions in Bill 173 that may stifle community responsiveness and flexibility. Although much of the details are left up to the regulations, the constant use of such language as "uniform rules and procedures" in section 1(e) and "prescribed criteria," "prescribed procedures," and "prescribed rules and standards" in section 20(4) in Bill 173 contradicts the rationale for a community-based rather than institutional-based long-term care system. Instead of ensuring quality and access, we're afraid these rules and criteria will create gaps and further entrench cultural bias and discrimination.

To illustrate this, let us revisit Mr and Mrs Wong's experience. To provide the most effective support to them, WoodGreen's CIA counsellor, who is culturally and linguistically competent, has to take on numerous roles. These include service coordination, advocacy and supportive counselling, as well as instrumental support. Unfortunately, this community-based CIA model has not been recognized in Bill 173 as one of the core functions of MSAs. The current case management discussed within the Ministry of Health is narrowly defined and restricted to service coordination. This approach proposed by the ministry and exemplified by Bill 173 clearly illustrates the prevailing influence of the traditional health care delivery system. Prescribing a case management system that lacks the holistic approach will leave the needs of consumers like Mr and Mrs Wong unmet, and they will be unable to continue to live in their community.

WoodGreen has similar concerns regarding the inherent cultural bias in the proposed system. Although the ministry has consistently highlighted its concerns for cultural and racial minority consumers, we have not seen any real indication that the proposed system will clearly remove the barriers for them, and although the consortium that WoodGreen has been working with in east Toronto has been trying to address these issues in our proposal, we find that community plans are continually frustrated by the district health council process.

Different cultural groups have different understandings of and experiences with health and social services. Working closely with the Chinese-speaking community makes us aware of their approach towards wellness. The traditional belief of health is one that is primarily preventive and based on addressing the root causes versus the symptoms. For this reason, WoodGreen coordinates one of the largest Chinese-speaking elderly persons' centres in Metro, with over 2,000 members. The members actively pursue volunteer, social and recreational activities that enhance their health and emotional and social wellbeing. For the same reason, our CIA and day program coordinators are working with many seniors who may not be considered eligible for MSA services because physically they are not frail enough, but their need for emotional and social support is crucial to maintain their independence.

We do not believe that Bill 173 incorporates such a preventive approach towards health and illness found in the Chinese community but also shared by other com-

munities as well. The legislation has not even mentioned the role of the elderly persons' centre. By prescribing an illness-centred approach in the legislation and regulations, we continue to entrench the cultural bias that is found in our current health care system and perpetuate a medical model.

0920

**Ms Margaret Bryce:** My name is Margaret Bryce. I'm on the board of directors of WoodGreen Community Centre. My section deals with the bill of rights and about the rigidity in the bill.

Another illustration of the inherent cultural bias in the legislation is the emphasis on individual rights. Now, WoodGreen obviously fully supports the incorporation of the bill of rights into the legislation. In fact, we urge the committee to include in section 3 the right to be free from discrimination on the grounds enumerated under the Human Rights Code.

After saying this, we have to caution the committee that the fundamental emphasis on individual rights that includes an appeal process is not necessarily relevant for all consumers from different cultural, racial and political backgrounds. It is meaningless for a Chinese-speaking senior to receive a piece of paper that states their rights. The power balance between the consumer, particularly those who experience historical exclusion, and the service providers cannot be changed with this paper. Consumers who are not aware and have not experienced any opportunity to exercise these rights to challenge inequities are not going to miraculously change. So there need to be some kind of funds available for the community work and there clearly has to be something in the bill that says these rights are available to the client from the very beginning, not just once they are receiving services. The actual entry point to the system must be covered by the bill of rights.

While we believe the bill of rights should be entrenched in the legislation, it is more important to ensure that the MSAs have the internal mechanisms to address inequities. At the same time, quality, service and system audits should be included in the legislation, which allow irregularities and contravention to be identified at a system level as soon as possible, before any one consumer has to pay the heavy price for it. I think that's a really crucial point, that there has to be adequate funding to allow agencies to do this properly.

It is important for the committee to understand the assumptions behind the proposed bill and challenge their validity. We've identified the bias but we also urge you to review the rigidity of the prescribed rules and uniformity.

We fully support guidelines and standards that appreciate a community-based system and incorporate concrete equity strategy. It is, however, contradictory to the principles of the long-term care reform bill if Bill 173 will create gaps and continue the process of exclusiveness. It is essential for the act and the regulations to provide a flexible, accessible and equitable framework so that rigidity and bias can be reduced.

Flexibility will allow MSAs to adopt approaches and

develop programs and services that are appropriate to the communities. At the same time, the bill should incorporate wellness and a preventive approach as the purposes of the MSAs. It should also include client intervention assistance as the key function and connect the MSAs with the role of elderly persons' centres.

Even when Bill 173 is amended to reflect all the goals and principles of long-term care reform, the ultimate determining factors for its implementation are adequate resources and community support. I think I should say that again: adequate resources and community support. This is obviously the cornerstone of achieving what we're after here. We believe that true commitment from the Ontario government can be shown when adequate resources are continuously put into the system to support neighbourhood multiservice agencies and long-term care reform.

**Mr Jim Wilson (Simcoe West):** Thank you for your presentation. I have actually a number of questions that I wrote down as you went through, but I'll cut to the chase because we had a multicultural organization earlier this week, represented by Dr Joseph Wong, indicate to this committee that one of the reasons we have to tear down the current system and replace it with a bureaucratic, rigid and very prescriptive MSA is that the current system is not responding effectively and in a timely manner to ethnic groups and individuals.

I had the opportunity to ask a similar question of Metropolitan Toronto, the organization representing home care, and I want to ask you the same question, because I note you start off by saying you think Bill 173 is a concrete step. But I want to tell you that my interpretation of some of the major flaws that you point out, including the exact opposite to what Joseph Wong told us, was that this bill actually has a cultural bias. We agree with you on that, by the way, and actually are calling for the withdrawal of the bill because it needs major fixing. The government clearly missed the boat on this legislation.

I'd like to give you an opportunity to tell us how you're responding to the cultural needs out there now. Again, I need to know, as part 2—you're having discussions I assume with the DHC—how are you going to fit into the new system, because once this bill leaves Parliament, it'll be DHC and minister only who determine how WoodGreen fits into the new system?

**Ms Go:** I don't think I would disagree with Dr Joseph Wong. I think we both agree that equity measures and strategies to combat the inherent systemic discrimination in the system have to be fully legislated. That's why I think Dr Joseph Wong and WoodGreen Community Centre have been supporting measures, anti-racism strategies and all that, to ensure that these are entrenched. I think what he would mean and what we are saying is that these should be included. Standards and guidelines of these measures should be included.

However, our concern is that because of the inherent bias right now in the system, we also have to look at, if we use the basic assumptions that we have right now in developing the model, then we are not challenging these basic assumptions. These basic assumptions of a medical

model of a not-preventive approach to health care delivery but an exclusive approach to health care delivery should be challenged. If we use those basic assumptions and put them into law to prescribe who would fit into long-term care, who would fit into MSA, to say that you have to be this frail to go to a day program, you have to be this and that to fit into the Meals on Wheels program, all these rigidities will just defeat what we are trying to build up in the long-term care system: an accessible system and an equitable system. I think what we're challenging is that kind of rigidity and the assumptions of the health care model that I don't think Bill 173 has been able to address.

To also secondly respond to the issue around the implementation, as we have mentioned, right now we are part of a consortium in the east end of Toronto proposing a neighbourhood model that is based on a collective approach that was built up by the agencies and consumers and community groups in the east end who have been working in this area for a long, long time and have been supportive of a model that is neighbourhood-based, flexible and all that. However, this proposal has been turned down by district health council, just because we don't fit in the population size, and again this illustrates the rigidity of this whole system. How can you at the same time say that we have to be accessible, community-based, looking at a community development approach, looking at what the consumers are telling us, and then say that we are prescribing this and this and that?

I think this is the core of this, to look at the match between the implementation process and the principles of long-term care and the principles and the goals of this legislation. We are very concerned that the implementation process is going to totally go against what we are trying to build in this legislation.

**Mr Jim Wilson:** You mentioned the DHC as a barrier to the consortium's proposal. Could you just explain what you just meant by "don't fit into the population size"?

**Mr Go:** When the DHC long-term care steering committee proposed a report to the ministry, they also prescribed the criteria for the development of MSAs. Those criteria included of course the government structure in terms of like who are representative or represented in your community process. We have no problem with that, to be inclusive and all that. However, among those criteria is also the size of the population of the MSA. It says it has to be between 100,000 and 150,000.

These population sizes have not been based on any cost analysis study that we have been informed of. We've been telling them that you have to tell us why this population size. We have no problem if you can prove that by cost-effectiveness, by accessibility, by getting rid of the bureaucratic system. However, that was not provided, but we have to abide by those rules.

It's very interesting. We are told to go for a community planning process, do it so you share, you'll be inclusive, try to draw on the people who would then collectively develop an accessible system. At the same time, they tell us, "You have to do this." It's like we have to do it towards a predetermined destination. I think it's totally contradictory to a community planning spirit. I think, if

governments would want to respond to that, you should examine those criteria. You should examine that to set up planning process criteria is very different from setting out criteria that say MSAs have to be like this and this and that.

**The Chair:** I regret, I know we could go on with questions, but our day is quite charged. But I do want to thank you all for coming today. As has been noted, some of these same issues have been raised as we move towards the end of our hearings. We appreciate the particular focus you've put on it this morning.

0930

#### VILLA CHARITIES

**The Chair:** I call on the representatives from the Villa Charities, if they would be good enough to come forward. Welcome to the committee. We have a copy of your presentation and also of the newsletter which you have provided for us and for which we thank you.

**Dr Marisa Zorzitto:** Good morning, bon jour and buon giorno. My name is Dr Marisa Zorzitto and I am a geriatrician and the president of Villa Columbo Homes for the Aged board of directors. I am here representing Villa Charities, together with Mr Pal Di Iulio, who is the executive director of the Italian Canadian Benevolent Corp.

Villa Charities is comprised of the home for the aged, the Columbus Centre, Vita Community Living Services and two apartment buildings for seniors and disabled people. Villa Charities operates day programs for seniors, frail elderly and developmentally handicapped people and provides educational, athletic, cultural, recreational and support service programs. We serve thousands of people who are of Italian and other ethnic origins.

We appreciate the opportunity to contribute our views to the members of the standing committee in your difficult task to ensure that the legislation being proposed is the best legislation to serve the people of Ontario, regardless of ethnic origin. We substantially agree with other submissions made to your committee, including those of the Multicultural Alliance for Seniors and Aging, the Human Services Alliance, the Catholic Health Association of Ontario and the Federation of Provincial Non-Profit Organizations Working with Seniors in Ontario. These groups have tremendous experience and knowledge and the trust of the public. Our principal comments on the proposed Bill 173 are as follows.

Firstly, equitable access to culturally sensitive services through designated lead MSAs: During consultations, through written and oral submissions, we and many other groups have emphasized the need for true access to services, in particular case management for thousands of people whose mother tongue is neither French nor English.

Each of you honourable members speaks an official language. Please try to imagine telephoning a number for help when you don't speak English. You can't understand what is being said by the person answering the phone, or, worse, the voice message system says press 4 for this language, 6 for something else and 1 for yet again something else. Of course, you hang up. If you don't find

someone to help you access the service, you don't get the service. You give up.

Due to the reality of demographics in our province, and particularly the greater Metropolitan Toronto, it is generally agreed that lead MSAs and satellites or storefronts are required for access to culturally sensitive services.

The proposed legislation states that "reasonable grounds" is a term sufficient to enable the minister to take over a multiservice agency. We submit that "reasonable assurance" for lead MSAs specializing in cultural, spiritual and linguistic needs should be enshrined in the proposed legislation.

Our first recommendation, then, is that the act should include wording assuring reasonable access to culturally, spiritually and linguistically sensitive services through the minister's designation of lead MSAs and require appropriate training of staff to refer and serve consumers needing culturally sensitive services.

The legislation requires that MSA boards reflect the composition of the geographic area they serve. As an area changes, so will the board of governors. When a lead cultural MSA is no longer required in the future, it will become evident in a changed board reflecting the demographics.

Secondly, we would like to talk about the partnerships with volunteer groups and governance. We believe that the majority of volunteer-based groups do not have vested interests; they have investments in their community. In these times of fiscal restraint, we need experience, time and support from volunteer groups that receive the trust of the people and can communicate with their communities.

Subsection 15(2) may be interpreted as a clause which sunsets the ability of the minister to exempt how community services are provided after four years and should be amended.

As recommendation 2, therefore, we would say the act should give assurance that volunteer-based groups are a valued asset to be encouraged, supported and continue their good work as full partners in the MSA system, together with the requisite board membership representing consumers and providers in the respective areas, and in providing services for lead cultural MSAs.

Given the millions of dollars involved in delivery of these important services, full and complete discussion of all aspects must take place prior to enactment.

Our third recommendation is that enactment of this legislation should not take place until either full and complete discussion of all pertinent facts on funding, transition, implementation and impact are thoroughly examined and reasonable consensus achieved from consumers and providers, or the proposed legislation should be purged of all but essential principles with the balance resting in the future regulations to the fact where changes or additions can be made when the system is fully planned and tested.

Our third recommendation refers to the community involvement. The Minister of Health gave authority to district health councils to design MSAs through commun-

ity consultation. Before many DHCs gave their recommendations, first reading of the act took place. The legislation proposed is for an untried system.

Our additional concerns relate to the extensive rules governing service providers in the proposed legislation. The bill of rights section of the act should equally give reasonable assurance for equitable access to services for consumers. While we are unable at this time to propose a solution, we believe that an alternative must be legislated which permits a consumer to seek recourse for ineligibility or exclusion from a particular service to an MSA group or a local level prior to a more formidable and less accessible appeal board.

In conclusion, then, members of the standing committee, thank you for your time. We urge you not to act in haste and to truly heed the advice which is being given to you by these various groups. The impact of your work affects all consumers: your relative, your friend and your neighbour.

0940

**Mr Larry O'Connor (Durham-York):** Thank you very much for your presentation. I guess one thing we have heard fairly clearly from people coming and representing different cultural groups and service providers in our community has been that they are far more comfortable with an MSA model than allowing the present quite often directed by health unit model. I think what I get from your brief here is some concern about the DHCs being involved in that.

As you know or may not know, this is the first time the DHCs have actually been enshrined in legislation, because up to now they've been there as a planning body making recommendations to the minister but have never actually been put in legislation. Now, for the first time, it's put in legislation and it's going to be looked at actually as a viable body, a body that actually is going to be enshrined in legislation.

Your concern, what I get from some of what you've presented, is that they may not represent the community in which they are serving. I wondered if you might have any suggestions, in that section of the bill that talks about the district health council, how we might make sure the district health council is as representative as possible of the community that it's going to be involved in the planning for.

**Mr Pal Di Iulio:** I wish it were easy. I guess it's easier in Wawa, Ontario, where essentially the DHC and the people it purports to serve are similar, homogeneous. In a situation like Toronto, where neighbourhoods change every 15 or 20 years, there's usually a time lag between the established groups and the incoming groups. I don't know what formula to use, other than it is very, very important. If the DHC doesn't have a feeling as to what's coming up, what will happen is that not all the communities that are moving into various neighbourhoods will have the expertise, the talent, the English-language expertise, be economically, socially entrenched to be able to contribute.

So it's a matter of, yes, of course, the community should push ahead and it should propose, should put its

best foot forward, but communities aren't blocks of people all working together. There are thousands of people, each with their own interests, and at the same time it is difficult for the established DHC council to replace themselves with people whom they don't know. That is a concern. I don't know an easy right-hand answer to that. But I think now I see that at least we're talking about it or becoming aware of it, whereas prior to these sorts of legislation: "DHC? What is that? Where is it?" It was meeting in camera, deciding the fates, and nobody was involved.

**Dr Zorzitto:** If I might add just a couple more comments, I would support the position that was taken by the previous group from WoodGreen. They emphasized the need for flexibility of models, population sizes in communities, and I would also emphasize we would recommend that the multicultural groups be taken seriously when they go to the district health council and have fair representation and be listened to in terms of the constituents they in fact represent and have communication with.

**Mr O'Connor:** Would you prefer the model as described coming from the community and through the district health council process over what we've heard from—for example, the other day we had a presentation by a public health unit saying, "We're the best people to be delivering this service and our board is elected municipal officials," so they know exactly what's best. They're elected councillors and they know what's best. Do you feel that the process we're trying, to bring it from the community up, as opposed to another level of government or this government being the ones who are saying what's best for your community—do you feel it's better to come from the community itself?

**Dr Zorzitto:** There is no question in my mind that the needs have to be defined by the community itself, perhaps through its elected representatives. But the more grass-roots one gets in terms of listening to people's needs and what their sensitivities are, the better the system will work and will truly meet the commitment which it is purporting to make.

**Mr O'Connor:** We've heard people talk about the home care program here, and in fact I believe the budget for it is about \$100 million. It could be called a bureaucracy with \$100 million. But the local planning process on long-term care: What involvement have you or your group had in making sure the cultural representation in the community that you represent is being put forward so that the planning takes into consideration your needs?

**Mr Di Iulio:** I was referring earlier to the sophistication of groups. Our community—if we can say "our community." The Italian-Canadian community's first attempt to do something of a community social function for seniors started in about 1973-74. At that point in time, as best we could understand it, we came up with an idea of a home for the aged.

For a while we thought that, with one home for the aged for 200 or 300 people, we could somehow alleviate a real problem, a real concern that was coming up. Well, we were fooling ourselves. It was a great first step and it somehow brought some togetherness in the planning of

the community, but here we are 20 years later, in 1994, and there are 50,000 to 70,000 people between the ages of 65 and 100 of Italian-Canadian origin. Most of them happen to live in the north or northwest part of North York, although not exclusively, and frankly, this is our second time around.

We, in the last couple of years, through these bills, were trying to get involved, trying to get a handle on it, but it takes time, it takes money. I can't say that we have all the full experts to be able to come to you with all the solutions. All we know is that somehow we want to be able to ensure that these 50,000 to 70,000 people, for the next 20 or 30 years of their lives, get some of the services that for the first 20 or 30 years of their lives—somehow while they were busy working in the ditches and the factories, they could never afford to go to English class and therefore now they can't access. So they become double losers.

So there's a bit of a morality play here. Some of us younger people feel a real responsibility. We don't know what the answer is, but we want to make sure that somehow we're in there protecting their interests, getting the services they deserve. Their number one fault is that they don't speak English; therefore, they cannot access most of the systems that are out there that may be accessible to people who are here and who did take time out to learn English or who in fact were born here and therefore speak English.

0950

#### OLDER ADULT CENTRES' ASSOCIATION OF ONTARIO

**The Chair:** I call on the representatives from the Older Adult Centres' Association of Ontario. Just to reiterate, because of trying to get as many presenters in as possible, we are limiting the questioning each time to one questioner and rotating by caucus.

**Ms Anita Machin:** Good morning. My name is Anita Machin, and I represent the Older Adult Centres' Association of Ontario as one of the vice-presidents. To my right is Bill Krever, the chairman of our business partnerships committee.

The Older Adult Centres' Association of Ontario has been promoting the work of older adult centres in Ontario since 1973. The association is committed to ensuring that the concept of older adult centres and the unique service delivery model used by centres are vital components of long-term care services for seniors in Ontario.

The membership of the older adult centres' association includes more than 150 older adult centres, representing over 100,000 senior citizens. The association provides services like education—workshops and conferences—advocacy, services to our francophone older adult centres, Ontario Seniors' Games, research information, regional activities, older adult centre standards, and certification for older adult centre staff and volunteers.

In Ontario, older adult centres have been in operation for more than 40 years. The very first centre sprang up to meet the needs of low-income older adults.

Following the Elderly Persons Centres Act in 1966, a number of seniors' centres were built with the help of

provincial government funding. Municipalities which had been working with senior citizens' clubs and programs built or renovated buildings as seniors' centres and provided the staff. In greater Toronto, centres sprang up as non-profit agencies with independent boards and more focus on social and health services than the municipal centres outside of Toronto.

As seniors' centres matured, they moved from social-recreation to multipurpose centres. The philosophy of the multipurpose older adult centre, which had its roots in the National Institute of Senior Centres in the United States, was one of a holistic approach to service delivery in an atmosphere of wellness with an underlying seniors-helping-seniors methodology.

Older adult centres are not only a service provider within the long-term care system, but they are unique in the way in which they deliver services. As defined by the Canadian Institute of Senior Centres, an older adult centre is a community focal point on aging where older persons come together for services and activities that enhance their dignity, support their independence and encourage their involvement in and with the community.

Older adult centres provide an important component of the delivery of long-term care services that goes far beyond the provision of basic services. Older adult centres are visible and accessible facilities in the community that serve a full spectrum of older adults, from those individuals who are extremely healthy to individuals who need vital services to remain living independently in the community. All of these services emanate from a wellness perspective and have the ability to encourage and enable older adults to remain living independently in the community.

Older adult centres are very representative of the communities they serve. One of the founding principles of older adult centres is the involvement of consumers in the operation of a centre, ranging from involvement in governance and participation in program planning to active involvement as volunteers.

A 1991 study of Canadian older adult centres indicates that the problems most frequently seen in members of a centre are, in order of frequency identified: loneliness, mobility/transportation, widowhood, health impairments, low income, isolation, depression, sensory loss, problems with using time and nutritional deficiencies.

The same study indicated that the services most often provided in seniors' centres are services which respond to those needs. We provide fitness, educational, recreational, arts and crafts and social programs, health promotion, health services, specialized services like legal clinics, pre-retirement programs, home support services, Alzheimer's community services, day programs, information and referral, and case management, which are just a few.

The Parks and Recreation Federation of Ontario has put together a list of social benefits that are derived from people who are able to access such benefits:

- Leisure provides leadership opportunities that build strong communities.

- Community recreation reduces alienation, loneliness and anti-social behaviours.

- Community recreation promotes ethnic and cultural harmony.

- Recreating together builds strong families, the foundation of a stronger society.

- Leisure provides opportunities for community involvement and shared management and ownership of resources.

- Integrated and accessible leisure services are critical to the quality of life of people with a disability and disadvantaged individuals.

- Leisure opportunities, facilities and the quality of the local environment are the foundations of community pride.

**Mr Bill Krever:** I would just briefly like to highlight the views of the older adult centres' association, including our general support for Bill 173, as well as two areas of concern that we have with respect to the bill. In making these comments, we are hoping to offer some viable recommendations that we feel we would like to see incorporated into Bill 173 that ultimately would improve the impact of the bill.

First, the older adult centres' association is fully committed to the principles and goals of long-term care reform, and in fact many of these principles are the concepts that are the underlying principles of older adult centres and they're concepts that we've been working with for many years.

Specifically, older adult centres are committed to providing single-entry-point access to services, providing a continuum of services, streamlining administrative functions, providing a high-quality service, promoting racial equity and cultural sensitivity. We are very familiar with the intent of the reform and we share the belief that this reform will benefit consumers of the long-term care system in Ontario.

There are, however, two areas of Bill 173 that we would like to discuss today and, in the process, offer some alternative approaches that we believe would improve the impact of Bill 173. First, we would like to highlight our views on social and recreational services as they relate to Bill 173 and multiservice agencies. Second, we would like to comment on the purchase-of-service limitations as outlined in Bill 173.

In terms of social and recreational services, let me first stress that the Older Adult Centres' Association of Ontario is very pleased to see that these services are included as mandatory community support services under Bill 173. We've been fighting many years for recognition of social and recreational services within the long-term care system and we're pleased to see that this is recognized. The recognition of social and recreational services is an important component of the health and wellbeing of individuals within the long-term care system and is consistent with the purpose and mandate of older adult centres in Ontario.

However, Bill 173 fails to provide a definition of what is meant by social or recreational services. It is our belief that unlike other services listed within Bill 173, social or recreational services are very difficult to define and very different in nature. Services such as meal services,

transportation services and care giver support services are very generic in nature and generally have universal definitions.

On the other hand, social or recreational services are not defined or directly linked to independent living. Participation in social or recreational services is an essential component of the wellbeing of any individual and are a function of personal choice and overall lifestyle. Participation in these services promotes independent living and community involvement, and they can also be viewed as preventive in nature.

The older adult centres' association believes that the provision of social or recreational services should not be defined from a service perspective within Bill 173 but rather as a concept for personal choice and wellbeing. The motivation of individuals to participate in social and recreational services should be the driving force behind the delivery of such services, rather than the services themselves.

The older adult centres' association believes that older adult centres have an important and unique role to play in the development of multiservice agencies. Further to this, it is our belief that older adult centres need to be recognized within the structure of multiservice agencies, based both on the services we provide and, more importantly, the way that we provide services.

The province of Ontario has been supporting centres since 1966 through the Elderly Persons Centres Act. This act provides up to \$30,000 per centre on a 50% funding basis. Funding is largely used for what we would call infrastructure purposes, and the actual funding for the services we deliver comes from other funding sources or from fund-raising.

With this existing resource available to the community and already being funded by the province, it is our belief that older adult centres, or elderly persons' centres as defined by the act, should be designated in Bill 173 as the primary provider of community, social or recreational services for all individuals within the long-term care system.

1000

So to this end, we have two recommendations which are enclosed in our brief. First of all, we've included a definition of "social or recreational services" which we think would be important to be included in Bill 173, and our second recommendation is that each multiservice agency in Ontario should be linked with an older adult centre or a number of older adult centres for the provision of social or recreational services. Also, in communities where there is no older adult centre currently existing, the Elderly Persons Centres Act should be used to develop new centres to serve those communities.

The second area that I'll touch on very briefly is the purchase-of-service limitation for multiservice agencies. Bill 173 limits MSAs from purchasing more than 20% of their services from other service providers, and I'm sure you've heard many different presentations on this topic. Our views on this come from two perspectives.

First of all from a general perspective, the restriction severely limits the ability of the MSA to purchase ser-

vices from existing service providers. As we know, there are hundreds of service providers in the province of Ontario that are already offering these services, and this limitation would restrict their participation. The older adult centres' association believes that long-term care reform and Bill 173 should build upon the strengths of the existing service delivery system and should not restrict this participation of existing agencies based merely on a budget ratio.

Further to this, our association is not clear on why 20% is used as a ratio and what the justification is for this ratio. We do understand that in the initial documentation it was 10% and now has been increased to 20%. We would see, if there has to be a ratio, a more acceptable level a little higher, or some justification for the level.

Second, specifically relating to social or recreational services, the older adult centres' association believes that these services should be exempt from purchase-of-service restrictions. The delivery of social or recreational services cannot be accomplished, in most cases, directly through a multiservice agency. They must rely on other service providers. The provision of social and recreational opportunities for consumers in the long-term care system involves providing access to an extensive range of services through a facility-based concept. Most of these services will not be within the context of MSAs and would require a duplication of services that already exist and are already funded by the province of Ontario.

So to this end, we have two recommendations. The first is that the purchase-of-service limitation of 20% for mandatory services be reviewed and revised to allow greater involvement from other service providers. It's further recommended that if it is necessary to have a purchase-of-service limitation, these limitations should be developed on a service category basis rather than across the board for all services. There may be some areas of service that better lend themselves to purchase of service than others, so we see it as perhaps being different for different categories.

Second of all, it's recommended that the social or recreational services within Bill 173 be exempt from any purchase-of-service limitations.

I'll turn it back to Anita for some concluding remarks.

**Ms Machin:** The Older Adult Centres' Association of Ontario is very supportive of the overall principles of long-term care reform and the major components of Bill 173. The association looks forward to being part of this new service delivery system and we welcome the opportunity to continue to work closely with the province of Ontario and all service providers within the long-term care system at both the local and provincial levels. Older adult centres will continue to work closely with local MSA planning groups, and we will continue to deliver high-quality services to consumers throughout the province.

The Older Adult Centres' Association of Ontario is hopeful that centres will be able to have an important role within the new long-term care system, and we hope that older adult centres will continue to be recognized as the primary provider of social and recreational services. We envision that a partnership between new multiservice

agencies and older adult centres will provide a solid base of social and recreation opportunities for all consumers within the long-term care system.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Thank you very much for coming. You are presenting on behalf of the Ontario association, as I understand it, but you both are working in Metro.

I would like to say that there haven't been many presentations about well seniors. There certainly are concerns about a lot of the things that are going to happen to those who are very frail and elderly and their care givers, but your service has been somewhat absent in presentation and I'm glad you've put it on the table.

What I think you do is keep people out of care for a lot longer. I think that in itself has to be considered. You didn't mention that too much, but I think it's a very important point of your service.

You're not the only group that has come before us wanting more refined definitions. I think yours, however, is one of the most pressing for definition because, without definition, I think it will tend to be—what should I say?—very foggy, mushy in service and in actual presentation as part of mandatory services. It likely will be at the bottom of many people's lists in some communities, and that certainly isn't where the consumer will be best served.

The ratio question has come before us at every centre we've been and many times in every centre. I don't think the government has any real reason for the 20-80, they have not been able to give one. It's the same as the other ratios that are found within the bill. We don't have a reason. I think you put that question again and I hope the government will take your comments in their seriousness; also the fact that it should be over the broad perspective and not specific regarding the allocation of the 20%.

I would like to ask you, because the government tends to continue to hold up Metro as being the only DHC that has really submitted plans, where you've been in that whole mix—I presume you have been part of the planning and at least presented to the DHC—where you see yourself at the present time—we all can only deal with the present because we don't know how and when this bill is going to be implemented and, as you know, there are transition stages—where you see yourselves now relating to any one of those 15 or 20 projected MSAs and where you've been in the planning of that particular strategy.

**Ms Machin:** The involvement has been entirely left up to the individual centres because, as an association based in Metro, we have very little control or input in the DHCs in the other communities. Some of the centres have been very actively involved; the association has since the inception of long-term care with our previous government.

Agencies are involved where they have the ability to be. If they are a large agency that has strong staff who are able to interact well with other strong agencies, it has worked well for them. But many of the centres are not operated by staff, or many of them are very small and just involved in the recreational wellness aspect and have

not necessarily been closed out but have not known or understood how they can access the long-term care system.

**Mrs O'Neill:** Do you think you've made your point that MSAs should be directly connected to elder centres?

**Ms Machin:** With our members?

**Mrs O'Neill:** On the Metro scene at the present time.

**Mr Krever:** To add to what Anita said, I think there is a problem, especially outside of Metro. In Metro, older adult centres are involved in the planning. For example, in the agency that I represent, the Don Mills Foundation, the older adult centre is just part of our operation, so our board and our organization are taking a lead role in developing a planning consortium. In fact, that application is being delivered today to the district health council.

Within our work and because we're a large organization, we can bring with us the older adult centres, but in a number of areas outside of Metro, especially where centres are much smaller, there's no consistency as to how centres are recognized and there's no mandate for planning consortiums to include older adult centres as part of the services. I think one of the things we've been looking for is some overall direction in terms of older adult centres being recognized as a core service. Once a service is recognized as a core service, then planning consortiums know that those services are essential to planning an MSA. If you're a link service or outside of that core basket of services, it's unclear in different areas. So we've been looking for, I guess, some overall policy direction as to exactly where we do fit. Many of our member agencies have been active in the process.

#### 1010

The one thing that concerns us is it's very inconsistent throughout the province, and what may come out with multiservice agencies, in some areas we may be included, in some areas we won't be, and that's merely because of the recognition or lack of recognition that we have, especially starting out in this process.

**Mrs O'Neill:** So you think the definition would certainly give a profile to your particular organization if the definition was clearer within the act?

**Mr Krever:** It certainly would. One of the things we see with social and recreational services, as we stated in our brief, it's more a concept than a service. It's not an individual service, such as Meals on Wheels and so on where you can see the tangible output. Recreation service, providing access to services, you need to provide a whole range of activities and services for people.

It really needs to be a facility-based program with a full range of opportunities and in order to do that you really need to be operating an older adult centre or have that infrastructure in place. By capturing some of that within a definition, then it would at least ensure that the concept of what centres are doing and what recreation really means to the older adult is captured.

The other thing we stress is that leisure opportunities in older adult centres aren't only for those people who are active and very well. Many of the consumers that use our services also are active users of Meals on Wheels, home support, even of home care type services. Recre-

ation services don't stop just because you become frail. They're throughout the whole system and they need to be integrated to the different abilities of the consumers within the system for all levels, not just the well elderly.

**Mrs O'Neill:** I thank you for your very focused presentation. I hope you will have success with your other centres in getting them as active as you seem to be in North York.

**Mr Krever:** Thank you.

**The Chair:** I'm going to just ask the parliamentary assistant to comment on the link between the elderly person centre and the MSA process as it now stands. Parliamentary assistant.

**Mr Paul Wessinger (Simcoe Centre):** Yes, thank you very much for your presentation. Certainly we all recognize the very important role that you play in health promotion and disease prevention. I thought it might be useful for the committee to have Mr Quirt explain how the elderly person centres will relate to the whole question of the long-term care funding situation and whether they will be funded separately and to what extent there will be a financial relationship between the centres and the MSA.

**Mr Geoff Quirt:** The elderly person centres will be funded from the long-term care program funding envelope but, clearly, elderly person centres can retain their independence and be funded separately if the local planning process recommends that to the minister. I think it's important, as you pointed out, that elderly person centres be at the table and fully involved in planning for the social and recreational needs of elderly people, and I think your point is well taken that their social and recreational needs don't disappear when they gain new needs for other types of support services.

#### ONTARIO HOME CARE PROGRAMS ASSOCIATION

**The Chair:** I call on the representatives from the Ontario Home Care Programs Association. Good morning and welcome to the committee.

**Ms Ruth Stewart:** My name is Ruth Stewart. I'm the president of the Ontario Home Care Programs Association.

**Ms Vida Mazza:** I'm Vida Mazza, the executive director of the Ontario Home Care Programs Association.

**Ms Stewart:** The Ontario Home Care Programs Association, OHCPA, appreciates this opportunity to present its response to Bill 173 to the standing committee. Given the time allotted, I would like to briefly describe our association and then we will highlight some of what we feel are the central issues related to the legislation which we believe must be addressed if the government's strategy to reform the long-term care system is to succeed. Our written submission will more fully address all of our concerns and recommendations for your consideration.

The Ontario Home Care Programs Association represents all of Ontario's 38 home care programs. It has over 4,500 employees. These include case managers, therapists, homemakers and nurses. The Ontario home care program was established under the Health Insurance Act and therefore is an insured benefit to all Ontario citizens.

Its goal is to provide the coordinated delivery of multidisciplinary health care and support services to individuals and their families in their homes, in schools and other community settings.

In 1993-94, the Ontario home care programs served over 3,000 Ontario citizens, caring for people of all ages with acute, long-term and palliative illnesses and physical disabilities. Today, the Ontario home care programs' budgets provide approximately 90% of the total provincial expenditures for community-based health and personal care services.

The key purpose of the association is to work to ensure that Ontario citizens receive quality assessment and effective coordination and delivery of those services. To that end, for the past decade the association has been advocating to the government for changes to the legislated mandate and policies that govern the Ontario home care program and has identified gaps and needs for the implementation and expansion of programs such as the integrated homemaker program, the assistive devices program and respite services.

Like others, we have worked in close collaboration with the government, hospitals, long-term care institutions and our community service providers, both at the provincial and local levels, to effectively plan and implement meaningful system change.

In general, while the association has several critical concerns concerning the bill as it stands, we are pleased to endorse four key aspects of the act.

First, the association endorses the principles and goals described in the purposes of the Long-Term Care Act, as we are strongly committed to a client-centred system based on values of equity, accessibility, responsiveness, consistency, efficiency and accountability. We believe that community planning, knowledgeable and sensitive to its local requirements, needs, resources and cultural and linguistic diversities, are key elements in the development of a user-friendly system.

Secondly, we applaud the principles in the bill of rights and an appeal measure for persons receiving community services. In a client-centred system, it is essential that individuals be empowered with information about their rights, the opportunity to participate in and challenge the plans and decisions about their care. We are, however, deeply concerned about the prescriptiveness of the mechanisms and protocols outlined in the legislation.

Thirdly, in part VI, concerning the multiservice agency, the association supports the integration of health and social services in the model of an MSA, whereby one-stop access, information and referral and service delivery are made available to the community. The need for flexibility and respect for local determination of the MSA model are paramount for the appropriate and successful implementation of a multiservice agency.

Lastly, under part VII, the rules governing approved agencies, the association is highly supportive of the principle of equity in a consistent, standardized assessment process with uniform eligibility criteria to ensure a person's requirements are evaluated and to reduce unnecessary duplication of assessments and services.

**Ms Mazza:** Just a small correction: Ruth had mentioned that we served 3,000—

**Ms Stewart:** Did I say that?

**Ms Mazza:** —indeed, it was 300,000 Ontario citizens. The association's members have carefully reviewed the proposed legislation and have raised a number of serious issues. Our concerns relate to the deinsuring of home care program services, the need for flexibility for the local determination of multiservice agency models, the recognition of case management as a mandatory service, the overly prescriptive nature of the legislation, the acute short-term care needs of persons receiving community services, and the human resource implications for community-based volunteers and workers.

With the amendments to the proposed legislation, the professional services, that is, nursing, physiotherapy, occupational therapy, speech-language pathology, dietician, case management and social work, and the support services of homemaking, transportation, medications, lab work, equipment and supplies, will no longer be an insured benefit under the Health Insurance Act.

1020

There is a significant difference between an insured service and a mandatory one. The bill introduces this subtle but notable move away from a provincial commitment by eliminating the safeguard of the OHIP listing of home care program services—see attachment I, regulation 452, Health Insurance Act.

At the same time, the government is promising more flexibility and an increased mix of community service to the public, yet the legislation gives no guarantee of adequate funding for services to meet consumer needs. With the introduction of envelope funding, decisions will be made at the local level about how these moneys will be distributed.

When the public believes it can access a comprehensive list of community services as it needs them, we may create situations where people are left at risk in their homes with limited or inappropriate services unable to ensure their safety. In these times of scarce resources and a demand for accountability, OHCPA, the association, urges the government to review its list of mandatory services and asks whether we will be able to provide the funds to support all these services in all communities.

OHCPA recommends that a smaller core of mandatory services essential to maintain independence be established. Each community should be allowed to decide within its funding limitations which additional services are essential to meet the needs of its local community.

In the partnerships document titled, *Guidelines for the Establishment of Multi-Service Agencies*, released in September 1993, the government reported that the "community planning and design of each MSA will be led by the local district health council through its long-term care planning committee. This will be an evolutionary process, requiring community planning and consensus building among existing local service agencies and consumers. We have no doubt this process of local empowerment will create MSA designs that best suit the needs of each community."

The document called for a fully developed and integrated MSA established through the amalgamation of provider agencies that currently offer a broad range of long-term care services.

In recent months, the Minister of Health recognized the significant challenge faced by community agencies in developing a plan for full amalgamation and integration of services. In fact, this requirement has been seen as a major barrier to any action towards service improvement and integration in most communities across the province. As a result, the minister has accepted the need for flexibility and the scope of service and organizational arrangements and will provide funding to support collaborative planning initiatives among local agencies as a developmental step towards MSA implementation. We had initially understood this flexibility to mean provincial acceptance of alternatives to amalgamation if a community planning process supported this.

With the release of the proposed legislation, we now understand that, in fact, this flexibility is for a limited time period—a maximum of four years.

The association's members strongly believe that it is possible to achieve the public's desire for the integration of the service delivery level and simplified access to needed services, which the government is committed to, through other forms of models as well as the amalgamation model.

In addition, OHCPA is deeply concerned about the untested assumption that with the amalgamation of service provider agencies in Ontario, cost savings will be achieved. On the contrary, there is substantial evidence mounting that the administrative costs, including those resulting from the human resource implications of the transfer of workforces, may indeed further erode the resources available for direct service to the client.

OHCPA recommends that the legislation be amended to also allow alternative forms of MSA structures which meet the principles outlined in the purposes of the act and are a result of the community planning process.

On the issue of governance, the majority of OHCPA's members support the consideration of all potential not-for-profit candidates, including municipalities and boards of health, if they are prepared to meet the requirements set out in the selection criteria established under the government's guidelines.

In part VII, section 20, the proposed functions of MSAs are outlined in Bill 173. These are the current functions of home care program case managers today. In all four of the government's partnership documents, references to the critical role of case management and its activities and services are clearly noted and laid out, yet there is no mention of case management in the act.

OHCPA is deeply concerned and must strongly criticize the absence of the role of case management.

With over 1,700 experienced and highly skilled home care case managers and home care programs today and countless others in community support agencies, the government cannot afford to neglect acknowledging the essential service they provide to the consumers of the long-term care system. Integrating all services through an

MSA will promote easier access and provide one point of entry, but it will not eliminate the complexity surrounding the array of services and what they offer.

We all want a model that consistently delivers the right service at the right time, in the right place and for the right price. We must recognize how complex that is. We need to be driven by the outcome of empowerment rather than the outcome of compliance or cost-effectiveness to arrive at a client-driven model. We need a fundamental shift in all our paradigms. We need a new language, we need to ask different questions and our models of client care need to enable participants to make choices that lead to self-actualization. This won't necessarily happen by developing standards and converting to a consolidated On Lok type case management model. It will happen by developing relationships that are based on trust, mutual respect, humility and profound knowledge.

The most important part of the process of case management is the engagement, where they build trust, clarify roles and negotiate expectations with the client against the backdrop of a holistic understanding of community services. Unless that step is taken, they cannot proceed to understand what the client truly needs. An intake worker or service coordinator doesn't cut it. It matters most that this be done; it is negotiable whether it is through a broker or consolidated model, because the degree of comprehensiveness can be altered in all models.

OHCPA strongly recommends that case management be added to part II, section 7 of Bill 173 and that MSAs include case management services as a mandatory service available to consumers as needed.

As mentioned earlier, OHCPA gives its strong support to the key principles and values for a client-centred long-term care system and applauds the government's establishment of standards such as a person's bill of rights along with his or her right to an appeal process.

We lend our voice of experience to others who have advised the government not to regiment or prescribe procedures in the legislation such as the appeals or consent section by outlining time frames and protocols.

The association's overarching concern for the implementation of MSAs is that they will be wrapped in bureaucratic processes and paper pushing mandated by legislative directives and regulations. We are further concerned that funds will be diverted from direct provision of services to the additional resources required for the implementation of legislative protocols such as human resources and its management, information systems, training and education and the development of standards.

Throughout the lengthy process leading up to Bill 173, there has been little acknowledgement of the needs of persons with acute short-term illnesses receiving community services. With the downsizing of the hospital sector and tightening of budgets, the development of innovative practices in the community setting has been essential to the health system's efficiency and effectiveness.

Practices such as the home-based traction program, home chemotherapy programs and community ethics committees can be found listed in attachment II of our

brief. It contains a catalogue listing over 200 innovative practices and services created by home care programs through partnerships.

Currently over 60% of admissions to home care's regular programs—that's excluding the school and integrated homemaking programs—are to the acute home care program.

OHCPA strongly recommends that the current services offered to persons in the acute home care programs be continued in the MSA. Furthermore, OHCPA urges that the government truly act on its expressed commitment to reallocate funding from the institutional sector to the community sector if it does not wish to provide community care for the acutely ill at the expense of the consumers of the long-term care system.

Around the issue of the human resource implications: Firstly, we urge the legislation to protect the valued role of the volunteer in both service delivery and resource generation.

Next, we join our community partners in voicing our grave concern for those whose jobs are at risk through the proposed forced amalgamation of MSAs. We ask that the legislation ensure that the rights of all community employees, both union and non-union, both management and front-line workers, are respected and that equal opportunities are available in work reallocation.

The association, along with its other long-term care community health and support service partners, has requested from the ministry protection for non-union staff similar to the protection afforded those under successor rights in the Labour Relations Act for unionized staff. OHCPA recommends that employee transfers to new agencies should be seamless, with no break in employment or client services.

In summary, the association is committed to achieving a system where consumers will have options, choices and the ability to control their own destiny, and that will cost less than the "do unto" approach. Thank you. We'll be glad to answer any questions we can at this time.

**1030**

**The Chair:** Thank you very much, and I just note for the record that you have left with us as well a fuller brief and that we appreciate that.

**Mr David Tilson (Dufferin-Peel):** The committee appreciates the positions that you've put forward in your various papers. I have two questions for you. One has to do specifically with the effect, in your opinion, of this legislation on the quality of health care in the province, and secondly, the effect on jobs of the people who are providing the service.

The first question: I'll read a paragraph of your remarks. It came from page 3, which had to do with the deinsuring of home care program services.

"With the amendments to the proposed legislation, the professional services (nursing, physiotherapy, occupational therapy, speech-language pathology, dietitian, case management and social work) and the support services (homemaking, transportation, medication, lab work, equipment and supplies) will no longer be an insured benefit under the Health Insurance Act."

That, to me, is a serious statement as far as the providing of the quality of service of health care in this province. I'd like you to elaborate a little bit more on that paragraph before I get into the second question.

**Ms Stewart:** As we see it, because the legislation does not refer specifically to the services being insured, we have some concerns that they will be looking for a less costly worker to provide services, and in fact that is being pursued right now through various committees in government. There is an assumption that the professional is not always necessary to go into the home, and while we agree with that, we feel that the very important roles that these workers do provide to the system must be both protected and respected, and where it's appropriate to use somebody who is less qualified and possibly less skilled to provide a certain service to somebody who has a long-term, standing disease or disability, that in fact should be done.

We're also concerned that as we move into this transition of the system, everybody who is now currently providing service has to be both continuing in a role as provider of the service, ensuring coordination, and at the same time working to evolve the system, and we have real concerns that there may be some disruption to what is being provided to clients. Certainly the home care programs are very committed to ensure that there is a seamless transfer of any responsibilities that might occur. So I guess it's really that as we see certain things not being described in legislation—the commitment of the programs has always been to have a quality product going to the client and we fear that there might be some compromise of this happening in the system.

**Mr Tilson:** Would that lead to an unequal form of health service—in other words, if you can afford it, you pay for it, and if you can't afford it, you do without—which isn't what we have now?

**Ms Stewart:** I think there is always the danger of that happening, and people are now purchasing services because there are many people who prefer not to come through a publicly insured system. I feel that the consumer who feels that they cannot get the service they want—and the legislation does refer specifically to the preference of the individual being paramount. I'm not sure how that can be provided for, frankly, under this current legislation.

**Mr Tilson:** The second question I have: The government, in fact the province, for the last number of years has been aiming at expanding home care services and hence your existence. So on one hand it's expanding home care services—it appears to be; at least that seems to have been the policy over the years—and yet, with this legislation, it's been projected by several groups that at least one half of the providers of community-based services—in other words, the private sector care services—will be eliminated.

I therefore get to the question as to the suggestion of jobs. On the one hand we commented on the quality of care; on the other hand, how is that going to affect your organization or the people who are associated with your association as far as jobs are concerned?

**Ms Mazza:** The proposed model suggests that the

workers within the service provider agencies will be moved to an MSA, and so there's certainly every indication that those workers would have an opportunity to have a job.

**Mr Tilson:** But on the other hand, the government's cutting back.

*Interjection.*

**Mr Tilson:** Just settle down, Mr O'Connor.

**The Chair:** Order, please.

**Ms Mazza:** The concern about jobs for us in particular, home care programs, and I know for our service provider partners, is around the issue of the union-non-union approach that the government has described in some of its partnership documents. It raised concern about perhaps an uneven approach to how they would treat unionized workers and non-union workers. We don't have safeguards for the non-union sector in our area, and so that's a major concern that we've been addressing with the ministry to date and we'll hope there'll be some resolution about it.

Around loss of jobs, if that's your specific question—

**Mr Tilson:** Yes.

**Ms Mazza:** —I'm not sure what that final formula will look like, the final outcome of all of that will look like, because there is a sense that we will need at least the number of workers we have now, but who does that work will be what's in question.

**Mr Tilson:** Parliamentary assistant, are you able to provide some security to the non-union sector?

**Mr Wessinger:** I think it's fair to say that there's no intention to give any legal preference with respect to the question of employment. I think the reference in the papers that were set out merely was to the fact that those people who have collective agreements have rights that exist under the Ontario Labour Relations Act, and that is just a statement of fact, not a statement of preference. It's just the reality that their rights exist under the Labour Relations Act for people who are part of a collective agreement, and there's no intention to give a preference on the government's part.

**Mr Tilson:** Mr Wessinger, my question was, can you provide—

**The Chair:** It's your final question.

**Mr Tilson:** One final question. That wasn't my question. My question was, can you provide security to these people who don't wish to become part of the unionized sector?

*Interjection.*

**The Chair:** Order, please.

**Mr Tilson:** Mr O'Connor, will you settle down?

**Mr Wessinger:** I think it has to be remembered that we have a Labour Relations Act in this province, and the provisions of that prevail. However, the suggestion of a seamless transfer of employment is certainly what would be the intention. There is a human relations plan that's supposed to be developed by each MSA. It's a requirement that that plan treat all employees fairly. The minister has said she will not approve a plan unless there's a

provision that treats all employees fairly.

**The Chair:** In calling our next witness, from the Freeport Hospital, we need to fix up some audio-visual supports here, so we'll have a short, two-minute recess while we get that organized.

*The committee recessed from 1040 to 1043.*

#### FREEPORT HOSPITAL

**The Chair:** I want to welcome to the committee Patricia Henderson, who's the executive director of the Freeport Hospital. Ms Henderson, I think we've got our technological devices set up here, so please go ahead. We have a copy of your submission.

**Ms Pat Henderson:** In introducing myself, my name is Pat Henderson; I am the executive director of Freeport Hospital in Kitchener, Ontario. Freeport Hospital is a chronic and rehabilitation facility. But as I address you this morning, I am wearing many hats. I've been involved locally and provincially for 10 long years in making long-term care reform happen in this province. I'm also a daughter, a daughter-in-law, a niece and a friend of consumers of long-term care in the province of Ontario. And I am an aging citizen of this province who does not want to reform any system and have it increase the burden on my children and my grandchildren as taxpayers in this province.

Before commenting on Bill 173, I have a short story that I wish to relate to you. I think it's very important that when you're dealing with legislation that affects lives of citizens, we bring the citizen right into this room.

Emily is an 87-year-old woman. She lived independently in her own apartment. She had high blood pressure and mild emphysema, but rarely saw her attending physician. She stopped taking her blood pressure medication because she felt just fine. Her closest relative, a granddaughter, maintained weekly phone contact with her and her great-grandson visited her periodically.

One day Emily's apartment manager discovered her on the floor in her apartment. She was rushed to the local emergency room where they diagnosed a stroke. Since Emily herself was unresponsive, no information about medical history, family contacts or even her physician was immediately available. Once the apartment manager tracked down the granddaughter, past medical history was retrieved.

Emily was admitted to a medical floor where she stabilized and became more responsive. A full medical workup was completed in a few days.

She was placed on a diet, and physical and occupational therapy began on the fourth day after admission. This is an unexplained deviation because therapy is normally started on the second day after admission. You can probably rest assured she had her stroke on a Friday. By the sixth day of Emily's stay she developed pneumonia. Information obtained after the onset of the pneumonia indicated it was due to aspiration of her food. It was discovered that a swallowing evaluation had not been conducted as part of the stroke workup. She was placed on antibiotics for the pneumonia. A feeding tube was introduced on the ninth day.

By the 13th day, Emily was doing better, so she was

transferred to the rehabilitation unit. The extenuating circumstances related to Emily's care increased the typical seven-day stay of a stroke patient on a medical floor to 13 days. Emily progressed well on the rehabilitation unit. She was performing simple activities of daily living and able to walk with moderate assistance and a cane.

After two weeks, Emily spiked a temperature and had to be readmitted to the medical floor from the rehabilitation unit. The fever was attributed to a urinary tract infection due to an indwelling catheter that was not removed in a timely manner. Emily was given antibiotics for the infection, but physical and occupational therapy were not reordered until the fifth day. She was too weak to tolerate their program, and so instead of returning her to the unit to continue the average four-week stay, they recommended nursing home placement.

The hospital social worker-discharge planner met with Emily's granddaughter to discuss and assist with placement. The granddaughter expressed surprise at the recommendation for nursing home placement and commented about how unprepared she was to make such a decision. Emily's granddaughter spent two days looking at nursing homes and decided to take Emily home with her. It was later learned that this decision was based largely on the fact that Emily's funds were tied up in bonds and debentures that the granddaughter did not know how to access.

Prior to Emily's discharge, the granddaughter received one day of limited instructions about managing tube feedings and general care for her grandmother. The social worker-discharge planner arranged for home care to provide a visiting nurse, therapy and supplies. Emily left the hospital on the ninth day after her second admission to the medical floor. The usual length of stay for a urinary tract infection is five to seven days.

The visiting nurse received little information about Emily's medical history or her functional status prior to discharge. Since the granddaughter did not have substantial information, much time during the initial registered nurse's visit was spent tracking down information from multiple sources and completing her assessment forms. The visiting nurse discovered that Emily's granddaughter was away from the home much of time and Emily's great-grandson spent much of his time with her.

Emily's family, with the help of the visiting nurse and the therapist, managed the first week. During that time Emily spent most of her time in bed because the granddaughter could not handle walking or transferring her out of bed. The social worker had earlier suggested adult day health services and an outpatient rehabilitation program as an option, but the family was too overwhelmed to follow up on the suggestion. No one contacted the community services to ask them to follow up with the family.

During her second week at her granddaughter's home, Emily became increasingly lethargic, developed an elevated temperature and complained of leg pain. The visiting nurse and doctor tried to evaluate the problem and suggest a treatment plan over the phone because it was just too hard to get Emily to the doctor's office.

At the end of the second week following discharge,

Emily was readmitted to the hospital with severe dehydration, gastrointestinal bleeding and a blood clot in her leg. At the time of readmission, she was unconscious, unstable, and her prognosis was grim. The emergency room had no current data about Emily's medical status and no further information about advanced directives, so they consulted the granddaughter when Emily arrived. The granddaughter was overwhelmed by the whole discussion and agreed to a "do not resuscitate" order, but requested that everything else be done for Emily. Emily was admitted to the medical floor and stabilized.

The staff of the unit learned that the severe dehydration was associated with inadequate flushing of the feeding tube. Emily was receiving a new type of tube feeding formula which required more flushing, and these instructions were not provided to the family. The blood clot was associated with the lack of mobility and the dehydration. The clot could not be easily treated with blood thinners because of her bleeding, and she also was too debilitated at this time for a procedure to place a filter near the clot to prevent breakaway and further complications.

1050

Emily regained consciousness and stabilized again. The staff on the medical floor believed her potential too limited to warrant physical and occupational therapy. They did not have ready access to information about Emily's functional level prior to this admission and also did not know that up until three months ago she was living independently. They saw a woman who required total care and recommended nursing home placement to the granddaughter. This time she agreed.

Emily was admitted to the nursing home 10 days later. Limited medical records followed her to the facility, so once again an assessment was conducted at the time of admission. On the fourth day after admission to the nursing home, Emily became short of breath and eventually non-responsive. Since the nursing home had no information about code status and treatment wishes, Emily was sent to the emergency room. She had developed a pulmonary embolism, probably a breakoff from the clots in her leg. She was admitted to the medical floor for the fourth time and was treated aggressively. Despite this treatment, she died at the hospital 16 days after her final admission.

Mr Chairman and members of the committee, I ask you, do you feel that Bill 173 as it sits before you today would have changed the fate of Emily?

Long-term care needs reform, there is no doubt, because it is a bureaucratic mess of pounds of paper between agencies, doctors' offices and hospitals, and even if the summary of what is on paper in any agency is shared, it is not shared in a timely manner. Creating paperwork was our solution to our problems in the 1970s and 1980s. If something wasn't working, we just created another system with all its papers and forms to make it work.

I feel strongly that Bill 173 has lost the overriding principles of long-term care reform; namely, coordinated and collaborative services providing a continuum of care in any community and equitable and easy access to ser-

vices for the elderly and the disabled. Creating another bureaucracy with its pounds of paper and its methods of collecting the same information that already exists all over the community is not going to fulfil these principles. It is not reform, this is not customer-focused, and it will not help Emily. Please recommend that a rigid, cookie-cutter design of multiservice agencies must be eliminated from the legislation. Communities must be allowed to build their own collaboration and cooperation.

Options, as many as creative, innovative communities can design, must be acceptable. For some, a federation of agencies linked by a community information highway with a joint board of directors might be just the answer. In another small community—many communities that I know—the hospital may already be functioning as the MSA. In other communities, the design outlined in the legislation might be just the answer. Please do not allow the prescriptive legislation of management methodologies and practices. And for goodness' sake, no one can legislate quality. Quality is a culture in an organization or in a community, and it's built on a value system. This must be allowed to be as unique as our communities are.

I, as a possible future consumer, ask you not to allow this legislation to turn me into a commodity in which I appear on a purchase order to be serviced and then I turn around and I appear on an invoice so that someone will pay for the services I received. This will constitute another paper bureaucracy, very expensive. I buy and sell within my own organization and I know what it costs to cut a purchase order and then cut an invoice. This will constitute a paper bureaucracy which will promote more delays. "Am I receiving what I need when I need it?" is the question we must be asking.

Emily needed an efficient, effective exchange of information between all the providers in the community, from the pharmacist who knew she had not renewed her prescription, to the family physician, to the emergency department, to the various programs in the community in and between the hospitals, to home care, to the family and to the nursing home.

I also have one final plea: that this committee as they make recommendations on this legislation not allow something as important as the proposed major change to the Ministry of Health Act giving the district health council conflicting powers of planning and advising, and now of managing. This requires extensive public consultation on its own. There is no way an act as important as this should have significant amendments buried in Bill 173, a long-term care act.

We are going to have so many people legislated with a responsibility of planning and managing our providers that we are going to constantly be spinning in a circle with district health councils, long-term care offices. Often we have municipal governments owning and operating many agencies and we have standalone agencies with volunteer boards of directors covered by corporate laws and orders of council. Further legislation mandating another body to micromanage the system is not going to enhance the original objects of long-term care reform. Coordination throughout the community will mean equitable and easy access for the consumer.

In coming down to Toronto on the busy 401 this morning, I thought, "I do not have the right to criticize this legislation without telling you what I would propose." You legislate where I can smoke. You tell me I can't drive without carrying a driver's licence. I would like you to consider empowering the citizens of Ontario to take responsibility for their own health and requiring me and every senior to carry current necessary information on their medical history on their person. This won't cost anything. It will just be, "Pass a law."

Many communities have systems whereby the elderly must have the information in their refrigerator so that the ambulance driver can get the relevant information. I carry with me always instructions in my wallet that I don't want a trauma unit to put me back together again if I'm in a serious car accident. I'm afraid that nobody will look in my wallet until long after they've tried to put me together again, but relevant information is right up front.

**The Chair:** Thank you very much, and in particular for the story of Emily, which I think provides a clear case and one which we can follow through.

**Ms Jenny Carter (Peterborough):** Thank you for a very moving presentation. I think you have proved quite conclusively that the present system isn't working. I think we all agree on that, but you have challenged us by saying, "Would Bill 173 have saved Emily?" You characterize what we're doing in the bill as increasing bureaucracy, more pounds of paper, depersonalization and so on.

I just want to put it to you that I don't think that is what we're doing, that in Bill 173 we're not setting up a bureaucracy. We are in fact empowering local communities to administer their own health care with community input, because the agency will be run by community boards which are elected from the members of the organization, and the provisions that have been made as to the constitution of that board are that at least one third, and hopefully more, will actually be consumers, people who have used long-term care or are using it or whatever, and also there will be representation for providers.

The logic of bringing together existing agencies into one organization is the very point that you're pursuing: that they're not integrated enough, that nobody knows what anybody else is doing, and that communications are inadequate. I think we're looking at a much simplified system whereby there will be one assessment of a person so that everything will be looked at together, and then the relevant services will be provided, with that central focus of pooled information as to what is happening.

**1100**

I'd also like to bring your attention to an article in the Star today where a senior citizens' organization, Senior Citizens' Consumer Alliance for Long-Term Care Reform, sponsored a study which was carried out by Price Waterhouse and they concluded that what we're doing here is actually going to save a large amount of money—the figure of \$90 million is mentioned—because administration will be reduced, the system will be simplified and more money will go into actual what you might call front-line care rather than into the bureaucratic intricacies that you fear we might be multiplying.

This group says that "seniors are worried that the NDP will lose its nerve to act or leave the new law too vague.... 'If something doesn't happen soon, our whole system is going to collapse.'" This is Jane Leitch talking.

"Various seniors' groups have been calling for reform for more than a decade, complaining that the current system is difficult to access, uncoordinated and often insensitive to their needs.

"The one-stop shopping model 'will significantly improve a consumer's ability to access the right service, at the right time, in the right place—at an affordable cost to taxpayers,' the alliance says in a report accompanying the Price Waterhouse study."

So in view of the things I've said, obviously you're right that information is crucial. I think your suggestion for carrying information is very simple and very sensible. I think we do need to make sure that organizations are very well set up to use modern forms of communication. But I'm just wondering what else you would suggest we should do, how we should organize differently to what we're suggesting in order to make sure that Emily would have had a better outcome.

**Ms Henderson:** I don't take argument with anything you've said. I've worked with the coalition on all its papers and everything. It is the 20% of the elderly and the disabled, you and I, who will not interface the system until there's a crisis: Those are the people I'm really concerned about. I cannot figure out anywhere in Emily's story—and you have to know, with the passion I speak with, that Emily is very near and dear to me, and Emily happens daily in every community in Ontario.

Where would the MSA have come in? Where would the assessment have been done in Emily's story? The MSA has negated the fact that 20% of our people interface the system—at least 20%, and I think it's more—in the family physician's offices and in the emergency department of a hospital. Those are key pieces of information.

In the long-term care reform, it will be very good for the elderly who will pick up the phone and want a service, but the majority of elderly never cry for help until there's a crisis. The MSA will not help them, and we will still be playing with lives with lack of information.

**Ms Carter:** But at least there will be simplified access, one phone call for long-term care services and, if necessary, one phone call for an advocate who would come to a person in some kind of crisis because they'd been neglected or abused. I'm not sure how we can simplify it further than that, especially since another person could make that call for the person in need.

**The Chair:** Would you have a final comment?

**Ms Henderson:** I guess the only other thing I wanted to say, with due respect to the member, is that I happen to co-chair the coordinating committee for the Minister of Health for the implementation of the chronic care task force. I have the job of trying to facilitate coordination from all the pieces that are going to come together in a community, doing it provincially, on behalf of the Minister of Health. I can tell you, there are pounds and pounds and pounds of paper being created.

**Ms Carter:** I hope we both agree we want to reduce that as much as possible.

HALDIMAND-NORFOLK TRANSITIONAL  
STEERING COMMITTEE

**The Chair:** I call on the representatives from the Haldimand-Norfolk Transitional Steering Committee. Committee members, their presentation is in the material that was handed out this morning.

We want to welcome all of you to the committee this morning, and if you would be good enough just to introduce yourselves, then we'll go forward with your presentation.

**Mr Ron Armstrong:** Ron Armstrong, consumer.

**Ms Margaret Toni:** Margaret Toni, executive director of CHARTS.

**Ms Mary Anne Baker:** I'm Mary Anne Baker and I'm director of the home care program.

**Mr Armstrong:** The Haldimand-Norfolk Transitional Steering Committee is pleased to be given the opportunity to address this panel. This committee is comprised of 18 members representing regional consumers, health care employees and employers from the for-profit and not-for-profit sector, the district health council and the long-term care area office.

In the beginning, a questionnaire focusing on key aspects of the bill was distributed to each member of the committee. The responses were collated and a consensus was achieved in the final draft. In order to be clearly and briefly stated, we have purposely chosen to present our comments in point form. They concern specific aspects of the bill that we believe are problematic, and we have noted recommendations for your consideration in most cases.

Firstly, regarding the purpose of the act, we endorse in principle the government's fundamental goals and objectives to achieve community service reform, notably in the area of one-stop access; improved community-based service system; consumer-focused system; improved and consistent accountability; and local community-controlled planning through district health councils.

Here we recommend incremental improvements within the system to achieve the goals and objectives of the reform without radical re-engineering of the system.

Another issue is that we are concerned that if appropriate funding is not provided to the MSA, the clients will have to resort to other sources of care—for example, private care—or the clients may receive no care at all.

Another issue would be that the bill emphasizes the community care requirements for the elderly and the disabled. The acute care and school-aged target groups are not identified within the bill.

We would recommend that the bill include reference to the acute group—acute home care program—and the paediatric treatment group—school health support services program. For example, the fiscal year 1994-95 year-to-date statistics indicate that there's a 17% increase in the acute home care program. Moreover, the case load acuity levels have increased.

**Ms Toni:** Another issue is regarding case manage-

ment. Case management is not denoted within the professional services clause, subsection 2(7). Case management is a professional service that encompasses the following key components: holistic assessment; service planning and coordination; resource management; alternate planning; and reassessment and discharge.

We would recommend that case management be explicitly recognized as a professional service in subsection 2(7).

Subsection 2(7) in the act does not limit the provision of professional services to regulated professions. We assume the government is recommending this in an effort to minimize health care costs. We too support cost-efficiency. However, we are concerned the act may be endorsing a system that lacks professional accountability and unnecessarily exposes the client to risk. For example, a visiting homemaker is trained by a professional to perform a specific clinical treatment. Our concern is that this skill could be transferred to another client where the treatment may in fact be contraindicated.

We would recommend that additional language should be provided that ensures that any trained but unqualified service provider who is delegated to complete professional functions be under the supervision of a person licensed with the Regulated Health Professions Act.

1110

Another issue we would like to discuss is, we support in principle the concept of a bill of rights for persons receiving services. However, the emphasis on consumer rights must be balanced with consumer responsibility. Consumers have a responsibility to actively participate in the care plan and work towards independence. We do not support a system that fosters consumer dependence.

We would recommend that language be developed in the act to define the consumer's responsibilities.

Paragraph 3(1)3 states that the recipient of services "be treated in a manner that recognizes his or her individuality," notably respecting "cultural, ethnic, spiritual, linguistic and regional differences." For example, the Haldimand-Norfolk region contains a population of Mexican Mennonites. Every effort is made to recognize their cultural and linguistic differences. However, we are unable to attract qualified workers from within this target population because they are not available or trained.

We would recommend that the government needs to articulate what is deemed reasonable within the scope of this clause. Moreover, funding is required to achieve the objectives of this clause.

It has been our experience that in some environments, case managers and service providers are placed at risk in providing care to the client. Locally, we all have policies to protect the physical safety and security of our employees. For example, we have encountered abuse of our service providers from Alzheimer clients when endeavouring to render care.

We recommend that a bill of rights for service providers also be included in the act that prohibits discrimination against the providers on the same basis as delineated for the consumer, paragraph 3(1)3. Moreover, language that safeguards the service provider from providing

service within an unsafe or abusive environment should be denoted.

**Ms Baker:** The amendment to the Health Insurance Act implies that home care services will no longer be an insured benefit. We agree that health care expenditures must be controlled. However, the combination of deinsuring and fiscal restraint may create a system that parallels the current hospital sector. Notably, priority cases will receive immediate service and waiting lists will proliferate. Competition for resources, hierarchy for dollars based on one's acuity rate, will not promote community cohesiveness.

We recommend that the government give careful consideration to the potential impact upon all residents of Ontario in accessing services by deinsuring home care, should home care become deinsured.

We are also concerned whether the creation of multi-service agencies will actually generate cost savings and efficiencies through the integration of services.

We oppose wholesale amalgamation of agencies. No precedent has been provided for a successful MSA. In fact, perhaps the converse is true. At the joint annual conference of the Canadian Hospital Association and the Canadian College of Health Service Executives, the speaker from Manitoba acknowledged that a "health reform pause" is in effect in his province.

We recommend that the government defer the creation of MSAs province-wide until a cost-benefit analysis has been completed to determine the fiscal benefits and the efficiencies of this model. We also recommend that the government consider utilizing the Haldimand-Norfolk region as the control area to complete a cost-benefit and efficiency analysis.

In subsection 13(2), the not-for-profit policy, we are opposed to the government's prescription of limiting the purchase of services external to the MSA to 20%. Our local experience validates that competition is fiscally responsible; it reduces complacency by an agency; it promotes quality, efficiency and innovation in service delivery. For example, locally within our region, competition has fostered the creation of specialized services and skill levels which have created positive client outcomes.

We recommend that the government eliminate the 20% figure and give each MSA community the flexibility to determine its level of outsourcing of services. Guidelines to determine the level of outsourcing could include the cost of the service, the quality of the service, as well as the waiting lists that occur from services that are to be delivered by the MSA.

**Mr Armstrong:** We support in principle an appeals process. However, the appeals board should be the last resort after the issue has systematically proceeded through local intermediary stages. This would promote mediation and resolution to occur at the local level.

The recommendation here is that the appeals board should become involved in resolving a client-centred issue only after the appeals system at a local level has been exhausted. The local appeals process should be generic and consistent across Ontario, with specific time frames assigned at each step.

We believe the act may precipitate numerous appeals. After all, the consumer's preferences regarding the type and amount of service are to be delivered by the MSA. Moreover, it will be difficult to rationalize services within the MSA capped budget. After all, a capped budget has the potential to affect client care.

Our recommendation here is that if the appeals board rules favourably for the complainant, then the government must make the commitment to fiscally support the ruling.

We support in principle a takeover option. However, the process defined in the bill is unilateral and contrary to the community decision-making process, a cornerstone to the reform.

We recommend that the external party responsible for evaluating the agency be a mutually agreed-upon third party who is chosen by the minister and the agency, and that the ministry provide the notice to the agency by registered mail versus letter carrier.

The next issue is that the MSA may provide services outside the government's mandate and funding allocation. In the event of a takeover, the government shall have jurisdiction solely for the services provided by the MSA through the funding envelope.

**Ms Toni:** We are also concerned regarding labour implications. With all workers unionized and employed by one agency, the potential exists that a complete shutdown of the MSA will occur should a strike occur, resulting in cancellation of all client services. For example, the Red Cross homemakers' strike adversely affected the availability of homemaking for needy clients within Brant county and the Dundas area.

We recommend that the government develop a contingency plan in the event the MSA experiences a strike. We also recommend the government designate all MSA services as essential.

**Ms Baker:** We also want to share some human resource implications. The September 1993 government document entitled *Partnerships in Long-Term Care: Guidelines for the Establishment of Multi-Service Agencies* acknowledged preferential treatment of unionized workers from the community-based sector. However, in Bill 173, no reference was made regarding job security for union and non-union workers in the community sector.

We recommend that non-union workers be granted the same protection afforded to unionized workers through successor-rights clauses in the Labour Relations Act, and that positions within the MSA be filled according to two criteria: (i) current non-union and unionized employees within the local health and social services sector; and (ii) that all job requirements are actually met by the candidate.

Lastly, we recommend the government assume total fiscal responsibility for any severance package for any employees who may become unemployed because the MSA is created.

**The Chair:** Just before going to questions, could you tell me what CHARTS stands for, please?

**Ms Toni:** Community Homecare and Rehabilitation Services.

1120

**Mr Tony Ruprecht (Parkdale):** I want to congratulate you on your very descriptive and detailed presentation, especially on the specific recommendations you're making. I know, and you would agree, that the Price Waterhouse study shows clearly the inadequacies of the present system and we know that for almost a generation seniors have been calling for change of the present system, especially in terms of trying to empower community organizations and community groups to do this now.

You have indicated here that essentially you are in fundamental agreement with some of the objectives of the bill: one-stop access, improved services, consumer-focused systems, accountability and the improvements in the district health councils. The basic point I think you're making, however, outside of these specific recommendations is that you are afraid there might be wholesale changes made that could be termed radical.

My question to you would be to try to determine the specifics of your fear. In order to maintain some of these objectives and indeed to enhance them, how do you think that can best be done—especially since the parliamentary assistant, of course, is listening very carefully on this—without major changes that you might term as radical? How can that best be achieved, in your opinion?

**Ms Baker:** I believe there isn't a quick-fix solution to this, no question, and the reform certainly is promoting a lot of change. The service provider agencies feel, though, and certainly endorse that one must be cognizant of how many dollars are available in the pot for health care. They do feel, though, that the wholesale amalgamation is not necessary. They believe that they are committed to the goals and objectives of this reform, and that if they are given the parameters under which to achieve those objectives versus putting all the agencies under one umbrella called MSA, they could in fact achieve all the objectives within the reform without radical re-engineering of the system.

We don't presume to have all the answers by any means, but we're committed to the fact that we don't think putting all the agencies together within one pot or within this structure called MSA may be the answer.

What we propose—and I'm not hedging your question, sir—is that if you do follow through to implement MSAs, you'd have that experimental group as well as a control group. Our area is a control group for you to look at the benefits, both fiscal as well as efficiency benefits, that occur within our control group and compare that to the experimental group. From that, perhaps the proof is in the pudding, so to speak, but perhaps it would be much more palatable for people from organizations to look at the results of the study and say, "Yes, this MSA will work and it provides a better system."

We are committed that some things that we can do locally, something so simple as a 1-800 number to access services, could be the answer to one-stop shopping, versus radically reorganizing all agencies within this one umbrella, again being cognizant of any duplication in services. We're already moving within our area to create one assessment tool so that when the case manager does the assessment, the same information isn't gleaned from

the client when the provider goes in. We believe we're capable of and have the experience and the ability to make changes to effect these objectives. But it doesn't need complete restructuring, and that's why we would offer our area as a control group.

Again, to give you a shopping list of how we could do many of these things without radical re-engineering of the system, I can't bring that before you today, but I'm pretty confident that our group as well as district health could work on avenues to achieve that end.

**Mr Ruprecht:** Then you are really convinced that these goals and objectives, which you really favour, because we've been crying out for change, can be achieved incrementally within these recommendations that you've made without a wholesale change. You think that's possible.

**Ms Toni:** I think one need only look at the transition steering committee in Haldimand-Norfolk. Various people, as you will see on your listing, have come from profit backgrounds, not-for-profit backgrounds, government, home care, consumer, and we were able to obtain a consensus to present to you today. We have differences of opinions, we work differently, but we maintained a consensus, and we have learned over those months to work with each other. So certainly even the basis of the communication base is already there in Haldimand-Norfolk.

**The Chair:** I apologize, but I'm afraid we're starting to run a bit late and I'm going to have to intervene.

**Mr Ruprecht:** I thought I could have another question.

**The Chair:** I apologize, Mr Ruprecht, but we are running a bit late. I want to thank you very much for the presentation, for the recommendations and indeed, to reiterate, the novel way in which you put those forward. We haven't had it quite as clear as that in all cases.

EDDIE KNAKOWSKI

**The Chair:** I then call on Mr Eddie Knakowski. Mr Knakowski, welcome to the committee. Please go ahead.

**Mr Eddie Knakowski:** First of all, I'd like to thank you for having me here and allowing me to speak. These things were in my mind for a long time, and now the election is over and let's hope we don't separate, we stay one country, because otherwise it will get worse in Canada financially, economywise and politically, and we will get a bad understanding worldwide. The best example was when in 1945 Germany was separated between the east and the west and given away by President Roosevelt. If you don't take all this into consideration, we will be in a lot of trouble.

I respect your Bill 173. There are just a few things I—and I've talked to a number of seniors, men and women, and they would love to see a few changes. I don't know if you're able to do this; you should try. I'll respect you anyway.

I didn't come here to criticize you. I don't criticize the government. I like Canada very much. Canada has been good to me, good to many, and we should not forget this. But at the moment—of course, it's been going on for quite some time—as Paul Martin said, the deficit is out

of control. So ladies and gentlemen in the government are trying to overcome the deficit to a certain extent. We can't do it all, but I agree we have to do something about it. But in order to do something about it, we should also take into consideration the administration. Do we have medical expertise? As far as medicine, when it comes to surgery, let's say, if a mistake is made, a wrong diagnosis performed, where does the patient—the older, also the younger; I'm not just talking about the older—the injured, find help?

1130

I'm talking from my own experience. I'm not mentioning hospitals; I'm not mentioning doctors. I have had very good experiences with doctors, and I have had bad experiences. I have had bad experiences with hospitals. I've been in hospitals off and on. I have talked to people; I have reached out to them. I care about them; that's why I'm here. I'm not just talking for myself. There is so much organization to be done. I don't care how they write things down. I'm not the best writer, but there is need for human understanding, for human caring.

Many times, I walk through the hospital halls. Luckily, my brain functions very well, but many of them do not any more because many doctors have prescribed so many medications or prescription drugs, and many of them are useless. If revenue would be less important, we'd have efficient drugs by the drug companies, the support of the doctors, your committee, workers' compensation and rehab centres.

I have seen it all, and I know what some people are facing. Men, women, I have seen children; they reached out to me, grabbed my hand, just talked to me. Many of them are just isolated in institutions. If this problem is not solved, it does not matter how many organizations you provide, it will not work. The cost will go up tremendously. You've got to have people with medical knowledge who are honest.

If there's a mistake made—because very seldom does a second doctor speak up for you or stand up for you—if this is the case, we should create, first of all, a special team of doctors who are capable, who are honest, who are not dictated to by the Ontario medical and hospital associations. I'm not running unions down. I think unions were a great thing, but they have gone overboard. Many times they protect, especially the Ontario Medical Association, the dishonesty of many doctors. I could go on.

I have been done wrong. I know quite a few who have been done wrong. They can't afford good counsel or a lawyer, but the Ontario Medical Association, they're able to provide this service, and many doctors take advantage of this; not all of them. A number of them, when you're there, they really try to cover up, because if something happens to you—like an incident with my ear happened eight years ago, and I've been trying to find help to get rid of my pains everywhere. My eardrum was punctured in a hospital.

As I said, I'm not going to mention hospitals. I had steel chips in my ear. It was syringed. Instead of taking it out using a special instrument or treatment, the ear was syringed. The eardrum was perforated, my right one. Some steel chips must have gone inside. The doctor I saw

afterwards, a specialist, said: "Ed, your ear should never have been syringed. Giving you medication, like Garasone"—some of the medications, as I mentioned to you before, are very dangerous.

I wish your committee would supply—I know there are good medical books around. There is one good one around and another one. It's the *Compendium of Pharmaceuticals and Specialties*, the 27th edition, which is used by doctors. It gives you good knowledge about what drugs do, what can happen. There are also good medical dictionaries, because for the ordinary person, there are certain individual words which are very hard to understand, but if you get yourself a dictionary from the University of Toronto, they teach it there, then you will understand. Another one is *Martindale*, 29 or 30, which also gives you an explanation.

Many doctors give you addresses and names, because they have experienced these drugs. This is what is lacking with organizations, it doesn't matter who they are. I have seen so many women and men suffering. They've been drugged. They get so many drugs, they don't know if they're men or women. As long as this is not stopped or looked into, the cost will go up tremendously because people will get sicker, they will get side effects.

Also, when you elect a director or supervisor, this person, man or woman, should have wide medical and also surgical knowledge, because so many administrators or directors are functioning now in hospitals. I am not just grabbing things out of the air; I know from experience. I myself have called organizations to get help for others many times. They say, "We can't do anything; you have to call so-and-so," or they slam the receiver on you. Then you go further, you call up the director who is responsible for this. He apologizes for this person who was rude to you.

This is what you have to look at, in my opinion, to get more medical—you should get a good doctor running the hospital; I know they have doctors, but sitting in the administration who is the director. So then the responsibility can be given to this person. Otherwise, you have to go through so many, and you will get no support and you will be run down. Even if you go to the professions, they get support from the Ontario Medical Association. As I said, going through the big expense regarding a lawyer, in many cases, if they've been hurt, many people cannot even afford it. In my opinion, this is not fair and honest towards the patient or the injured.

I think the law in Canada has to be changed so that the individual who is being taken care of is protected from malpractice and wrongdoing. I know the service is available, but I know doctors—not all—take advantage of the service by the Ontario Medical Association. You think I'm running them down, but I know how they operate.

Every time you read an article in the paper, it will be delayed or it's just put under the table. The physicians and surgeons tried to implement, to make different rules to protect the patient. Every time they made a recommendation, the Ontario Medical Association interfered, and there was a delay. I brought only two articles along for you. I have many others.

1140

**The Chair:** I'm sorry, if I could just interrupt for a moment. I know there's one questioner. Perhaps you might just wrap up your comments. If you have some material there you'd like to share with us, the clerk could take that and make copies of it.

**Mr Knakowski:** Okay, fine. Lastly, even the profession's board—I'm not running them down—in many cases protects the doctor, even though they know he's not telling the truth. He is also protected by counsel, even if he damages you for life, which has been done in many, many cases; I know. If you get the right lawyer, if you can afford it, you might have a case. I'm not running doctors down. We need good, conscientious, caring doctors; we do have a number of them, but many of them just care about money and greed, and the patient comes second or third.

So everybody, including myself, has a responsibility towards each other. In many cases, if you get attendance right away if something goes wrong—we all need help at times; we don't know it all, even doctors—if help could be supplied immediately, we would have less patients in the hospital and less frustration and agony, and the patients could be helped immediately. I guess that's all I have to say.

**Mr Gary Malkowski (York East):** Thank you for your presentation. I'm going to ask the parliamentary assistant to make a couple of comments regarding the patients' bill of rights, which is included in the legislation to ensure that they respect the patient's right to choice and the right to access information, for example, when they talk about medication, because you were talking about the concerns of the patient. So I'll just ask the parliamentary assistant to comment.

**Mr Wessinger:** I think perhaps it's appropriate if I ask legal counsel to indicate the rights in that regard.

**Ms Gail Czukar:** The bill indicates that people have eight rights that would apply in any situation where they're receiving community services from any agency that delivers them for long-term care, and those would include the rights to be treated with courtesy and respect, to be free from abuse, preserving dignity and privacy and autonomy and that sort of thing. So I suppose we can assure you that, at least with respect to long-term care community services, attention has been paid to the rights of the individual, and it provides a basis also for groups such as patients' rights associations to have a platform from which to advocate.

**Mr Malkowski:** Are you comfortable with what you've heard this morning from legal counsel?

**Mr Knakowski:** Pardon?

**Mr Malkowski:** Do you feel happy with the comments you've heard in response, the protection of patients' rights?

**Mr Knakowski:** Yes.

**The Chair:** Mr Knakowski, thank you very much for coming before the committee this morning. We appreciate it.

**Mr Knakowski:** You are welcome. Thank you all.

## OLDER WOMEN'S NETWORK

**The Chair:** I call on our final witness for this morning, the final representatives, rather, from the Older Women's Network, if they would come forward. We welcome you all to the committee.

**Ms Ethel Meade:** My name is Ethel Meade. I'm a co-chair of Older Women's Network. Next to me is Moira Bacon, a member of our council, and Evelyn Turner, who is the chair of our community care committee.

Older Women's Network is grateful for the opportunity to present its views on Bill 173, An Act Respecting Long-Term Care.

While we are affiliated, nationally and provincially, with major umbrella groups of seniors' and women's organizations, we ourselves are a membership organization. We fill a gap in both the seniors' and the women's movements, because seniors' organizations rarely address women's issues and the women's movement rarely addressed older women's concerns. Our main purpose is the empowerment of older women to overcome injustices and inequalities at home, in the workplace and in society by public discussion and by participating in a variety of community planning activities.

One example of the public discussion we initiate was the Home Alone forum last April, where the Minister of Health headed a panel of health care providers to answer questions from health care users on the platform and in the audience. The impetus for that meeting was the death of an 82-year-old woman who had been sent home from hospital in her hospital gown and left alone, with no care in place. Since the forum, we have gotten together with 14 other organizations, both consumer advocacy organizations and community service organizations, to press for appropriate transitional care when seniors are discharged from hospital before they can care for themselves.

In the area of community planning, a number of our members have been active participants in the consultations preceding the drafting of Bill 173 and we are continuing to participate in advisory committees on its implementation, as well as on hospital restructuring and the planning of neighbourhood MSAs. Our members also participate in a variety of community bodies, such as the Toronto Status of Women Committee, the Safe City Committee, the TTC's advisory committee on planning future subway stations, the Social Planning Council of Metropolitan Toronto, the Advocacy Centre for the Elderly, Trans-Action Coalition and the CMHC advisory committee.

As women continue to form the majority in the proportionately larger older segment of the population, the need to focus public attention on older women's concerns is increasing. Our work keeps these concerns on the public agenda while we challenge the stereotypes of older women with our visible community activism and our creative activities.

1150

Older Women's Network has been interested in the reform of long-term care from the beginning and we welcome and support the aims and objectives of this proposed legislation. We commend the emphasis on con-

sumers' needs and the protections embodied in the bill of rights, section 3. Improvement in the delivery of in-home support services is overdue and we believe the new system will, in providing one-stop access, bring about a considerable enhancement of access to services. The comments on some aspects of the bill which follow are not meant to detract from our support for the aims of this planned reform. Our hope is to make feasible suggestions for its improvement.

First, family care givers: While never granting them recognition or financial compensation, long-term care planning for the frail elderly has always assumed that family care givers, usually women, would carry most of the burden. Community-based services were designed to give them some help and support, but never enough to substitute for their unpaid labour.

This has not changed with the introduction of Bill 173, but the world in which we are growing older has changed. There are now more seniors than ever before and even the rate of increase in our numbers is still increasing. But there are now, for many reasons, fewer available family care givers. Families are smaller today and more scattered. A large majority of the women our daughters' age are in the labour force, as single parents or as members of two-earner families.

The disincentives to leaving the workforce to care for elderly relatives are numerous and high. A wife who takes early retirement to care for an ailing husband takes a distinct financial loss for which there is no financial compensation. The loss will be particularly severe if, as is often the case in the present senior generation, she has started her career late because of child care responsibilities. A daughter who leaves the workforce to care for an elderly parent may not only damage her career prospects irretrievably; if she is 45 years old or more, she may never get back into the workforce at all. In either case, her pension credits, and therefore her future economic security, will be drastically reduced.

The reform of long-term care in Ontario still depends hugely on family care givers, but they now constitute a shrinking pool. The bill as presently written does nothing to lessen the disincentive for family members to leave paid employment for this role. It allows for homemaking services to ameliorate the care giver's burden, but these are services for which a fee may be charged. No fee exemption has been built in for care givers who are forgoing paycheques, nor is there a guarantee that any substantial time off for rest or recovery from any illness of their own will be provided to them promptly in emergencies and without cost.

Since the unpaid labour of family members, usually women, is the foundation on which community-based long-term care must rest, we strongly urge that family care givers be guaranteed three weeks' holiday time per year, plus whatever sick leave they require, the cost of this respite care to be completely covered by the appropriate MSA. To do this would be only minimal justice and some small encouragement to those who take on the care giver role. We must remember that the community, as taxpayers, could not conceivably finance the long-term care of the elderly without them.

Moreover, women who take time out of the workforce to care for young children can take up to seven years off without affecting their Canada pension plan entitlement. While this is a federal matter, we believe that the ministry should join us and other seniors' organizations in urging that this provision be extended to those who care for elderly relatives. Similarly, the income tax deduction for child care expenses should be expanded to include costs for elder care. Because family care givers are vital to the success of the plans envisaged by Bill 173, we think the Ontario government should take seriously every opportunity to make their situation more viable.

**Ms Moira Bacon:** The right of appeal against decisions of an approved agency outlined in section 32 of Bill 173 should be extended to family care givers, who may be as seriously affected by such decisions as the person cared for. Moreover, the freedom to appeal without fear of repercussions is particularly important to seniors and to their care givers because of their actual and perceived vulnerability. The act should therefore spell out the safeguards of this freedom.

Along with the freedom to appeal and the bill of rights, seniors and their care givers should be free to complain about inadequacies in the quality of care received. The only way they can be free of fear in reporting poor service is to provide a complaints bureau with the kind of independence and privacy protection now accorded to the Ombudsman's office and with the power to investigate and enforce appropriate standards. This provision should supplement, not substitute for, the proper monitoring of standards by the service-providing agencies.

**Transitional care:** Hospital discharge teams must be required to contact the appropriate MSA when a senior patient is discharged from acute care. The restructuring of Ontario's hospitals that has so far taken place has already made our hospitals into leaner and meaner institutions. Discharge from acute care is now enforced at the earliest possible date, which for seniors is often considerably earlier than they are able to care for themselves. For seniors living alone, this can be a life-threatening situation if adequate in-home care is not immediately made available.

Neither the care presently offered nor the care contemplated by Bill 173 can meet the needs of senior patients in the week or two following discharge after surgery or major illness. During this period, such patients may require 24-hour-a-day attendant care, in addition to visiting professional and personal support services. The availability of such enhanced in-home care must be considered an extension of the patient's rights under the Canada Health Act. It is a substitute for what only a few years ago would have been a normal extended stay in a hospital or in a convalescent facility. The substantial cuts that have been made in hospital funding necessitated the present quicker and sicker release from acute care. Some of the money saved must be made available for the enhanced in-home care that is now essential.

Older Women's Network, together with a task group on transitional care consisting of 15 service and advocacy organizations, has been and will continue to urge the ministry to stop this gaping hole in the seamless care it

intends to offer through Bill 173. Regulations under the bill will not, as it is presently written, be able to address this problem. An amendment must be made to guarantee in-home care to the required level in the two weeks after discharge from acute care.

**The role of family physicians:** We support the position of the Ontario College of Family Physicians that discharge teams should be mandated to contact the patient's family physician before discharge and that MSAs should be mandated to include the family physician in assessing patient needs and planning for their care. Family physicians should also be able to access in-home services for their patients.

**Eligibility criteria for persons applying for services** have not been included in Bill 173. We assume that this is being dealt with through regulations in order to make possible future changes in criteria without recourse to legislative amendment. This assumption is only partly reassuring, however, because eligibility is the most important single aspect of the system of long-term care being proposed. By dealing with it in regulations, the government makes it possible for itself and future governments to use the narrowing of eligibility criteria as a means of meeting fiscal targets.

We also note with dismay that the advisory committee the ministry is consulting about eligibility and MSA design is lacking in consumer representatives. We feel therefore that the public should know and have an opportunity to respond to the eligibility criteria before the bill comes to third reading.

**Volunteerism:** We have some concern about the future of volunteerism in the highly structured long-term care system that will be established when the bill becomes law. While the bill does contemplate the continuance of volunteer activity, there is the potentiality for loss of spontaneity in community involvement. The least that can done to obviate this danger is to mandate a volunteer coordinator in every MSA.

1200

Finally, our deepest concern is about funding. Whether the promises of seamless and adequate community-based care for all can be achieved depends entirely on the enabling funds that are committed to it. Unlike the Canada Health Act, Bill 173 does not enshrine the right to care. An improved system of service delivery has been designed that should, in theory at least, make the available funds more effective. A small amount of additional funding, \$400 million over three years, has also been proposed, but we have grave doubts that this amount will do more than cover administrative costs and increases in the numbers of the affected population between now and 1997.

The present community-based long-term care is inadequate, as well as fragmented and difficult to access, but improved levels of care are not guaranteed by a better delivery system, desirable as the latter may be. This is made clear by the provision for wait-listing in subsection 21(2). Will all the careful consultation and planning that has gone into the preparation of Bill 173 result in the right to get on a waiting list for an essential service?

We consider Bill 173 a very important initiative, representing a good start on the reform of long-term care in Ontario. We want to see it go ahead expeditiously to provide the improved access to care it was designed to achieve, but we hope also that in the process, the suggestions we and other organizations have made will be thoughtfully considered, to the benefit of the elderly and to their care givers.

**Mr Tilson:** Thank you. It will give the committee many thoughts, and hopefully the government will react, specifically to two of the items you've raised in your presentation. One is with respect to volunteerism and the other is with respect to funding, which appear to be your major concerns with respect to this legislation. It's not the first time, of course, that individuals have come to this committee, and I guess the whole issue—I'm going to ask you to elaborate more on those two issues, specifically with the first one on volunteerism.

Perhaps you could tell me what you believe will be the impact of the multiservice agencies on volunteerism. There have been concerns, specifically by such groups as VON, the Red Cross, the Kidney Foundation, that the volunteers, and the thousands of dollars that they raise for health, are simply going to disappear.

**Ms Meade:** I don't know if it's going to disappear, but it's certainly going to create a different atmosphere for volunteer activities. Originally, almost every charitable community effort started out with the spontaneous action of a couple of people who saw a need and talked to a couple of other people and got a little something going and then spread it a little bit and finally began to get some funding and then finally became established as an organization that performed a community role. That kind of spontaneity seems to me very unlikely in an atmosphere that is as highly structured as these MSAs are going to be.

You also have the prospect of people who have long-time connections with community organizations feeling not as comfortable with the new structure and losing their energy, the enthusiasm, what makes them go. The thing that makes people give their time and their energy to volunteer efforts is often fed by the personal attention, by the personal connections, by the relations that they have with members of the staff of the organizations. I don't know how that's going to be affected, I don't think anybody knows, but we do think some special efforts need to be made to try and counteract an effect that is very likely.

It's not possible, I don't think, for anybody to predict exactly how this is going to work out, but if we have it in mind that volunteer work is important and necessary for all this to work, then I think having a volunteer coordinator mandated for each MSA is one of the things we could do about it.

**Mr Tilson:** The second question I have has to do with funding and its relationship to the whole issue of quality of health care. It's become quite clear that the home care services are going to be deinsured. The professional services, the support services will no longer be an insured benefit under the Health Insurance Act. It's been said by many groups that've come to us—and I guess I'm address-

sing my comments for further elaboration on point 7, which is funding, in your paper—that with this, and the added cost of bureaucracy and the fact that there has been no cost analysis as to what all this is going to cost and there are going to be even more bureaucrats providing less service in fact with respect to quality of care, with this legislation there will be a step backwards as far as quality of care is concerned. Could you comment, or do you have any—

**Ms Meade:** I'm more of an optimist. I think it'll stay even.

**Mr Tilson:** I'm sorry.

**Ms Meade:** I say I'm more of an optimist. I think we'll break even, that the extra money being introduced into the system may cover the extra administrative costs and the increased number of people who will need the service. But the fact is, we don't have enough service, and there's nothing in this bill that is going to give us more service. It's going to make it more accessible, easier to get, and that's all to the good and we're all for it, but that isn't all that's needed.

**The Chair:** Final question.

**Mr Tilson:** I guess my question that I want you to comment specifically on is the deinsuring of services. There's going to be a whole slew of services that members of the public have had in the past, everything from nursing to transportation, which are no longer going to be insured.

**Ms Meade:** My understanding was not quite like that. My understanding was that nursing, professional services and personal support services were to be free under this act; there were to be no charges for them. The only charges that seem to be contemplated are for home-making and, what was it called, community support?

The fees are being worked on, as I understand it, by committees. We don't know what they're going to be. It certainly is our position that they should never be an obstacle to anybody who is in need of care because they can't afford these services.

I wouldn't call that altogether deinsuring. I think nursing services will be provided without cost to the patient, and personal support, which I presume to be coming in and helping people get baths and things like that, will also be without cost.

We are concerned, however, with family care givers who give up a job and cut their income drastically in order to care for a family member having to pay for any kind of help that they get. We think they should be exempt from any fees that are levied in connection with homemaking, which is one of the few supports that's available to them.

**The Chair:** Thank you all very much for your presentation and coming before the committee. The committee stands adjourned until 2 o'clock this afternoon.

*The committee recessed from 1209 to 1405.*

**The Chair:** The standing committee on social development begins its afternoon session.

At the outset, I note both for members and also those who are watching on television and those who are in the

room, we have a very full agenda of presenters. The committee decided, because of the number of groups and individuals who asked to see us, that we wanted to try to hear from more people. The only downside to that is that it limits the time for questions. We felt that we'll have our opportunity in the Legislature to discuss some of these issues and the critical thing was to get people from the province before the committee.

That being said, most of the time, because of the time pressures, it means we can only have one questioner and I just wanted to indicate at the outset it's not because we don't have more questions to ask, but we do want to make sure we hear from as many people as we can.

#### SENIOR CITIZENS' CONSUMER ALLIANCE FOR LONG-TERM CARE REFORM

**The Chair:** I invite the representatives from the Senior Citizens' Consumer Alliance for Long-Term Care Reform to come forward. I want to welcome you all to the committee. We have received a copy of both your presentation today and also the report you had commissioned, which I imagine you will comment on in the course of your remarks.

**Ms Jane Leitch:** I'm Jane Leitch, the chairperson of the Senior Citizens' Consumer Alliance on Long-Term Care Reform. With me is Maryon Brecken from the Consumers' Association of Canada (Ontario), Allan Burnside from the United Senior Citizens of Ontario, and Beatrix Robinow, also from the consumers' association.

The Senior Citizens' Consumer Alliance for Long-Term Care Reform represents one million seniors and their families. While our individual members have been active in this debate for over the past decade, our alliance was formed in 1991 to give seniors and their families a unified voice in the dialogue about how services should be delivered to the elderly.

There appears to be no consensus among the stakeholders about how the long-term care system should be organized. However, while there is no consensus about what to do, after a decade of analysis, consultations and studies, we do know what the problems are. Simply put, they boil down to two issues.

The lack of coordination within the system: This lack of coordination results in seniors being shuffled from one agency to another, constantly being assessed and reassessed and often faced with gaps in services. Consumers have said it as clearly as they can, "We want a seamless system."

The second item is the high administrative costs of the system composed of over 1,000 single-service agencies. This of course is where the rubber hits the road in this debate. While nobody disagrees that dozens of agencies within a single community each have their own administrative structures for intake, assessment and payroll, human resources etc none of the provider agencies really wants to rationalize their operation. And why should they?

We believe that any attempt by any government to address the issues of coordination and duplicated administration will inevitably lead to something that looks like the multiservice agency concept. Our alliance strongly

endorses this concept as an alternative to the current system. We strongly believe that MSAs will be more efficient than our current community-based system.

However, while we support the MSA concept in the introduction of Bill 173, our members have a number of concerns about the current draft of the legislation because we believe it does not achieve the outcomes that the government has stated as the goals of long-term care reform.

Specifically, we feel this legislation needs improvement because the government's reform policies promised consumers a seamless continuum of care, but the legislation in fact creates a host of new provider distinctions, maintains traditional community-based program areas and does not integrate community services with the rest of the health system.

The reform promised local community empowerment, but the legislation actually creates a framework of rigid, centralized control which actually discourages local innovations.

The reform promised consumers empowerment and strong voluntary participation, but the legislation actually creates a situation where MSA boards may be restricted to only one third consumer representation.

And the reform promised alternatives to institutional care, but the legislation actually removes OHIP protection from some community-based services and maintains user fees on a range of others.

Our brief will highlight a number of amendments to address these specific concerns. However, we want to be perfectly clear with the committee: We want Bill 173 amended and passed into law. We don't want to be kept waiting any longer.

Throughout these committee hearings, we know that you've heard from many organizations and individuals who are prepared to acknowledge the need for improved coordination but are not prepared to acknowledge the need for streamlining of services. We are very well aware that the MSA creation is complex, emotional and difficult.

Changing the status quo is never easy. We know that improvements in accessibility can be achieved without fully integrating our current multitude of community-based organizations, as required by the MSA model. We also know that, in the short run, more modest reforms might be easier to achieve and therefore more politically popular in the months preceding election.

However, our alliance is absolutely convinced that more modest reforms are not in the medium- or long-term best interests of the province as a whole because, while they might improve accessibility, they do not address the equally important challenges of improving the effective use of the system's limited resources. Simplified access won't mean much if there are no services to be had.

On April 18, 1994, Canada's Finance minister, Paul Martin, announced that in the next federal budget in the spring of 1995, there would be massive cuts in transfer payments to the provinces for health, social service and education, and this morning there was more on that.

We believe that if communities fail to develop compre-

hensive reform strategies that include their entire community-based sector, many of our existing, not-for-profit community-based agencies will simply collapse. We fear this would lead to rapid development of a two-tiered community-based system where only the wealthy can afford the services they need. Consumers do not want this to happen. Therefore, we're calling on each and every one of you to avoid allowing this legislation to be compromised in ways that minimize the ultimate objectives of full organizational integration.

Our perspective is based on the considerable learning that our members have accumulated through consultations with various stakeholders on this issue. Virtually every consumer and provider group that our alliance heard from during our hearing process expressed frustration over their existing home care programs brokerage model, which separates assessment and case management from service delivery. It was felt that this model was too rigid to respond to consumers' real needs, and resulted in the costly duplication of work and administration.

The vast majority of consumers and providers we heard from categorically rejected the service coordination agency, SCA, concept proposed in the government's discussion document. This concept, which was virtually identical to the earlier Liberal government's service access organization concept, focused solely on simplifying consumer access to the system. Both of these concepts were rejected by the majority of both consumers and providers because they maintained the costly brokerage system and therefore did not address the high administrative cost of the current system.

It has been conservatively estimated that the administration and overhead cost of our plethora of single-service community agencies consumes 30% of expenditures for community-based care. I'd like to ask the members of this committee to focus on that 30%. This represents about \$200 million currently being spent on administration rather than service provision in our community-based system.

Whether or not to streamline the thousands of single-service agencies within our current community-based system to ensure the survival of a public system of community-based care will be one of the tough choices governments will have to face in the coming years. Our alliance wants to know, where will you stand?

Consumers' assumptions about multi-service agencies: While our written submission to the committee proposed a number of specific recommendations for amending Bill 173, we want to focus our time today on highlighting some of the assumptions that we've heard about the MSA model and clarify the alliance's perception of these issues.

First, we often hear concerns that MSAs will not be more cost-effective than the current system because the overall administrative cost to volunteer agencies is relatively low. At a press conference earlier today, our alliance released a costing analysis of the current and fully evolved MSA models prepared for us by the firm of Price Waterhouse. Copies of this report are included with our submission to this committee. In that report, Price Waterhouse have stated that conservatively, administra-

tion and overhead accounts for 30%—almost \$200 million—of the expenditures within our current community-based long-term care system; and within a fully evolved MSA model it is conservatively estimated that expenditures on administration and overhead will fall to 16.2%, allowing approximately \$167 million of our current system's budget to be redeployed in service delivery.

Price Waterhouse findings are consistent with a 1986 comparative study of two different home care program models in Calgary, Alberta. This study concluded that when case management service is separated from service delivery, as our current system is, there were 36% more visits, each visit cost 21% more and clients retained on the case load for longer periods of time. Taken together it was calculated that total cost of the brokerage system was 48% higher per client.

We know that many organizations throughout the province are operating very efficiently. However, the cumulative effect of having a multitude of single-service providers operating separate and apart from an independent case management infrastructure creates a tremendous administrative burden.

Another concern that's often raised is that the MSAs will be large government bureaucracies that are accountable to Queen's Park, not their own communities. MSAs will no more be government bureaucracies than hospitals, community health centres, existing non-profit community-based agencies or other transfer payment agencies. Furthermore, Bill 173 makes it very clear that the MSAs are to be independent, non-profit community organizations governed by representative community boards.

Fear over loss of agency choice is certainly a myth from a consumer's perspective since, today, choice of agency is often dictated by the home care program's contracts. Furthermore, our alliance believes that the area where choice is paramount to the consumer is his or her relationship with an individual providing hands-on care, not who the agency employs.

Another fear often expressed about MSAs is that they will undermine volunteerism within the community-based system. Our alliance does not believe this is valid. In fact, we're very optimistic that given the high degree of local participation required in MSA development, local volunteer loyalty will be maintained. Furthermore, we suspect that MSA models may actually generate higher volunteer involvement through coordinating volunteer recruitment activities and the ability to offer volunteers a great range of programs to volunteer for.

While it's true that some volunteers may have strong identification with particular agencies, we believe that the majority of direct service volunteers identify with the consumer whom they serve. We believe these personal relationships will remain in the MSA creation model.

The allegation has been made that MSA creation will have a devastating effect on fund-raising. We are confident that if MSA boards were made up of committed, community volunteers, they have the potential for greater success in local fund-raising because they would be capable of mounting comprehensive fund-raising campaigns that would eliminate the current competition

between community agencies for scarce fund-raising dollars.

We have heard concerns that the MSA will be in conflict of interest since it's both the purchaser and the provider of care. We do not share this concern since this dual responsibility already exists within public hospitals. Furthermore, we can't imagine this conflict being an issue if assessments are conducted by multidisciplinary teams of professionals, all of whom are accountable to their own professional colleges.

The alliance analysis of Bill 173 reflects our own assumptions about what the outcome of MSA creations were meant to achieve. Overall, we feel that while there are a number of very positive elements to Bill 173, the current draft of this legislation is too vague in some crucial areas and too prescriptive in other areas. As a result, we have a number of concerns about the bill's ability to actually realize the stated outcome.

To eliminate service fragmentation within the legislation, we recommend the current program distinction contained in Bill 173 be eliminated, and replaced with the comprehensive listing of mandatory MSA services. Subsection 12(2) of Bill 173 requires ministerial authorization to provide services in addition to the mandatory MSA services, and we think this should be eliminated. A clause should be included which empowers MSA boards to establish relationships with other community resources to ensure a true continuum of care for MSA clients.

Our alliance believes that unless MSAs are assured global or per capita funding, it will not be possible to achieve the design of a truly seamless system of community services. Therefore, we recommend that Bill 173 clearly state that MSAs will be funded on a global and/or capitated basis.

#### 1420

Our alliance is very concerned that Bill 173 has been written to encourage the wide establishment of user fees and means tests throughout the community-based long-term care system. We do not accept, given the waste and duplication in our current system, that user fees are an inevitable consequence of long-term care reform. Therefore, we recommend that Bill 173 be amended to say consumer charges and means tests are not permitted under the reformed long-term care system.

We believe the legislation is far too vague in its guidelines on board composition for MSAs. One of the greatest concerns is that MSA boards will emerge as federated governance structures dominated by existing long-term care service provider organizations.

To strengthen the governance structure of the MSAs, the alliance recommends that the legislation be amended so that consumers, current and former users and members of the community not currently working in the long-term care system must make up the majority of the MSA board; employees of long-term care service provider organizations are prohibited from becoming board members of the MSA; and MSA boards should establish professional advisory committees to provide the necessary health and social service expertise.

The alliance is pleased that Bill 173 amends the Health

Insurance Act to allow services currently provided within Ontario's home care program to become part of the MSA. We believe that this amendment sends an important signal to the communities that full organizational integration is the intended outcome of MSA development. However, we're extremely concerned that the protection consumers once had that home care program services were insured under OHIP has not been retained in Bill 173.

To address this issue, we recommend that Bill 173 be amended to continue to insure under OHIP those home care program services that are currently insured in the health care insurance act.

Our alliance fully supports the bill of rights outlined in Bill 173. However, to strengthen its impact, we recommend that Bill 173 be amended to allow the minister to order sanctions or fines on agencies found in violation of the bill of rights.

We support the legislation's requirement that all MSAs establish a quality assurance mechanism. To enhance that quality assurance program outlined in the legislation, we recommend:

- Explicit provincial standards for quality be established using the work of the Canadian Council on Health Facilities Accreditation as a possible model.

- Require that MSA quality assurance programs include measures of consumer and employee satisfaction.

- Require that the results of the MSA QA program be submitted annually to the district health councils and that the public be permitted to review that material at their local DHC.

The alliance fully supports the establishment of an appeals process. However, we're concerned that having a provincial appeals body as the only mechanism for consumer appeal will be too intimidating for many consumers.

To address these issues, we recommend that Bill 173 be amended so that in addition to maintaining the provincial appeals structure, each MSA board be required to establish its own impartial appeals complaint tribunal which reports back to the MSA board.

Since a central thrust of Bill 173 is to ensure that consumers have simplified and improved access to a wider range of community services so that alternatives to institutional care exist, we believe that the legislation's requirement that approved agencies keep waiting lists needs strengthening.

Therefore, we're recommending that service waiting lists be monitored by MSA boards on a quarterly basis at minimum and that MSA waiting lists be shared with district health councils in order to facilitate coordinated regional management of emerging service access problems.

We applaud the legislation's intent to give consumers the right to access their own personal records. We believe these mechanisms will be essential if consumers are to become meaningful, credible partners in their service plan decisions.

Therefore, we urge that part VI, subsection 29(2) be preserved unchanged in this legislation.

In order to maximize the full range of professionals within the MSA, our alliance would like to see the legislation specify multidisciplinary assessment and service plans.

Therefore, we recommend that Bill 173 be amended so that part VII, subsection 20(1) reads, "Assess the person's requirements using a multidisciplinary approach."

Finally, our alliance is pleased to see the role of the district health councils enshrined in the legislation. However, while the district health councils have been given numerous mandates to provide leadership in the reform of their local acute, long-term care, mental health and primary care systems, they still do not have legislation to govern them. We therefore recommend that DHCs have their own act governing their mandate, authority and accountabilities.

In closing, our alliance would like to emphasize with this committee that our members see the success of long-term care reform and MSA creations as critical to the wellbeing of elderly consumers and their families. We do not want this legislation delayed any more. Many of us have been talking about reform for years; now we'd like to see some action.

We are therefore looking to each and every member of this committee not to undermine the MSA concept but rather to take a leadership role, within your caucuses and within your communities, to help forge a shared understanding so that reform can continue to move forward as quickly as possible.

Thank you for your attention and we would be glad to answer questions.

**The Chair:** Thank you very much. I wasn't sure when we started how you were going to be able to get through so much material, but you did a superb job of summarizing that. Again I'll just note that you have also provided us with the report that was commissioned by you and that we've read about today.

**Ms Leitch:** Right.

**The Chair:** We thank you very much for that. Again I regret very much that we have such a limited time for questions, but there's a great deal of material, needless to say, in your document which we will be looking at very carefully.

So with that, I'm going to ask members this afternoon, again because of the time constraints, to have a question and supplementary. You'll feel right at home with that because you'll feel you're back in the Legislature. Ms O'Neill, if you could set the first example.

**Mrs O'Neill:** Thank you, Mrs Leitch and other members of the alliance. I have met with you on more than one occasion.

I'm very happy that you were so forthright in your presentation this afternoon. I think you have done an awful lot of work on this bill and I think we should be very happy and thankful that you've done that. The role of the minister, the global funding, the OHIP coverage, the appeals process being local, the waiting list, the multidisciplinary approach to assessment, those are all things we've heard from several of the presenters to this point and you have given us explicit recommendations on

how those could be incorporated in this bill.

I didn't have a chance to go to your press conference this morning because I've been here, but I wanted to ask you if you could say a little bit to us about the assumptions that that study took and how you feel about the assumptions, because in some ways I think they tie in with some of your concerns about the bill. The assumptions regarding the costing levels—this is on page 3, if I may, of the report you gave us—are that the MSA will incur higher administrative costs than the current home care programs due to expanded scope of responsibility. That'll be distributed 30% to administration and 70% to consumers and then the case management funding remains at the 1992-93 level and the diagnostic expenses remains at the 1992-93 level for the MSA budgets. Do you agree to those assumptions? I find those assumptions quite worrisome because of the growth of the population, because of the mandatory basket. I guess I'm finding difficulty with those assumptions. I wonder if you've had a chance to discuss them with Price Waterhouse.

1430

**Ms Leitch:** I think Allan Burnside is prepared to answer that question.

**Mr Allan Burnside:** On the assumptions that Price Waterhouse used, they were using the 1989, I believe, figures that were provided by the government and by various agencies. We feel that they are still valid today because the assumptions that—well, they came up with a figure of \$197 million in the current system, and on their analysis they come up with a surplus of \$91 million. So there is a saving there in the administrative cost on the community programs, and they've done this all the way through.

**Mrs O'Neill:** All right. I just wondered if you had questioned them on their assumptions.

My supplementary then: You have expressed in your first concern that Bill 173 does not integrate community services with the rest of the health care system. I'd like you to say a little bit more about that. I want to be sure I'm interpreting that correctly.

**Mr Burnside:** Is that the—

**Mrs O'Neill:** You have that on page 2 of your brief in your very first concern.

**Ms Leitch:** Would you repeat the question, please.

**Mrs O'Neill:** Your very first concern on page 2 states that, "Bill 173 does not integrate community services with the rest of the health care system. I want to be sure I understand that.

**Ms Leitch:** There are a lot of support services that are community services that are not covered under the health system, and we feel that it's very important that that be part of the whole picture, but that that shouldn't cost us more money if we can save it in a lot of other ways. This indicates that if there's assessment and service delivery from one point, it will save a lot of money in management fees and so on, and all this will be able to pick up, we think, a great deal of money that can be used for direct services. We'd like to think that some of the community services, some of the social services were also included in that.

**The Chair:** Thank you very much. I think it's fair to say that after we've had a chance to look at the report that was commissioned, individual members may have some further questions where we'd want to get back to you, and we will do that, but I want on behalf of the committee again to thank you both for the brief that you provided us with today and for that background document.

**Ms Leitch:** Thank you very much. We hope you will read it all.

FEDERATION OF PROVINCIAL  
NON-PROFIT ORGANIZATIONS  
WORKING WITH SENIORS IN ONTARIO

**The Chair:** I call on the Federation of Provincial Non-Profit Organizations Working with Seniors in Ontario. We want to welcome you to the committee.

**Dr R. Gordon Romans:** I'd like to start off by complimenting the committee on the extension of the period for consultation, because I think the maximum consultation is going to be required in order to get highly satisfactory long-term care.

The federation of non-profit associations working with seniors in Ontario fully supports the original direction of the new long-term care, where it's equality of access and the fact that it was consumer-driven. As you are likely aware, the federation has responded at various times during the proposed development.

More recently a letter was sent to the minister concerning the apparent discounting of the role played by volunteers in the system. The use of volunteers is cost-efficient, but not for nothing. It is hoped that the task force and the role of volunteers will define the expected use of volunteers and will pay attention to problems of recruitment, training and retention of volunteers. This of course will assure the large part of the success of the new care system.

The federation, as you probably know, is a group of about 13 or 14 associations which are listed in our brief. You will realize that, as with all partnerships, the federation evolved over four years based on mutual respect, consultation, negotiation of differences and the primary goal of meeting consumer needs. By accepting a developmental, process-oriented approach, the federation has successfully mediated among conflicting points of view to establish common positions and practical solutions to problems.

With such a diverse group of members, the federation's approach in reviewing Bill 173 has focused on areas of complementary views. However, some of the individual organizations holding membership in the federation have not had the opportunity to review and/or endorse this brief. Therefore, the following federation comments do not necessarily reflect or represent the views of the Ontario Community Support Association or the VON or indeed the Red Cross. It is my understanding that these groups are all making their own submissions.

After reviewing Bill 173, An Act respecting Long-Term Care, it is evident that the province has attempted to implement those values and principles. The draft legislation recognizes the importance of consistency in

the design, delivery and funding of community services, as well as the need for equitable access to services across the province. The province has also attempted to address the ongoing concern of consumers with respect to the need for information about, referral to and coordination of services to improve the process of access.

The principles contained in the redirection paper in 1991 appear to have been lost in some aspects of this bill. As an example, the consumer is not seen as the focal point of the system. The consumer has been replaced by the MSA and its set of rules and procedures.

The service system was to be integrated. In Bill 173 we see fragmentation, segregation or severance and continuing distinction between some services.

Cost-effectiveness has to be a central element. The MSA model with its inherent prescribed structure and operation will not be cost-efficient and will actually siphon funds from service delivery to implement the new multilayered bureaucratic structures.

Although the draft legislation is a well-meaning attempt to reinforce the government's vision, it is so detailed and prescriptive that it will result in the province micromanaging the system. Moreover, the legislation defines a rigid system based on eligibility criteria, rules and procedures and does not respect the many strengths of the existing system.

Legislation is not the place to be overly prescriptive; prescribing the details of the system belongs to regulations and guidelines. I might add that it will be easier to change the regulations at the end of the four-year period rather than redesign the legislation.

#### 1440

The federation presumes that the primary purpose of the legislation is to ensure that consumers have access to appropriate care, but the statements do not speak of the original vision of meeting the needs of the consumers by creating an integrated health and social service system. Also, there is no mention of support to families and care givers in the statement of purpose.

The federation compliments the province on its determination to implement the ideals of the original redirection. However, it questions some of the means proposed in Bill 173.

The draft legislation prescribes regulatory processes that virtually assure the development of a rigid, inflexible and hard-to-change system. At the beginning of the redirection, people asked for improved access to services, elimination of repetitive assessments and an improved information and referral system. The draft legislation, perhaps inadvertently, marginalized consumer requests in its quest to redress the imbalance between facility-based and in-home-based care. This indeed is leading to a cookie-cutter legislation, which the minister repeatedly says she doesn't want, and indeed leads to what we might call micromanagement.

The design of multiservice agencies: Presumably, district health councils across the province are working within their respective communities to design and develop MSAs. Ostensibly, the province intends to encourage local community involvement in planning. Yet before the

DHCs have had time to design their MSAs, the draft legislation proposes the form, administrative structure, accountability and service configuration of the agencies.

The federation would request the release of information with respect to the service need projections and an accompanying outcomes assessment based on cost analysis of the legislation as it has been presented before third reading.

The federation requests that the province reconsider the criteria for designating programs as fully funded to permit broader application of user fees subject to a simple, non-intrusive means test such as is currently used by the home support service agencies.

Will the MSAs refer clients to services that it does not provide or if they are not eligible for MSA services? Will the service plans and other relevant documentation be written in plain language for the benefit of clients? And will the people be able to access additional services if the system's financial resources are unable to provide for their needs?

The rest of our brief is detailed consideration of the various parts, and we have presented today in the form of a table which becomes easier reading than to listen to verbally, but it is designed for two things: It is designed to make the system less cookie-cutter and it also is designed to remove some reasonable sections from the bill to be put in regulations, where they can be more easily adapted. Those parts would pass comments on part I of the regulations and suggest some amendments:

- To recognize the person's needs as the most important factor in managing and delivering community service, and individual preferences as another major factor.

- To ensure that a wide range of community services are available to people in their own homes and in other community settings appropriate to their needs.

- To promote equitable access to community services, both across the province and within communities, using a person's needs, consistent service and assessment standards.

Then, going to part II, the draft legislation perpetuates the fragmentation caused by the existing distinction among community services, particularly those categorized as community support, homemaking and personal support services. The listing of services must be adjusted to permit sufficient flexibility to accommodate as yet unforeseen services and client needs. There again we suggest some amendments to section 2 to bring these things about.

Going on to part VI, and here it has to do with the governance: In keeping with previous comments, the federation suggests that the draft legislation represents an attempt to micromanage the system. The province evidently does not trust the basic district health council-led community planning process which it has proposed and which is being implemented in communities across the province.

Finally, the province is sending out a very unfortunate message in relegating municipalities and boards of health, both representing the electorate, to a secondary place for consideration as multiservice agencies.

I think I might add here, to divert, that the MSAs haven't been sufficiently defined, to the best of my knowledge, that there is any ability to estimate the expected model of the new system, namely, one-stop access. At the moment, to the best of my knowledge, I find that there are going to be at least 15, if not 19, MSAs in the metropolitan area, and this certainly is a complication when it comes to making access to the system.

Seeing you have all the other suggestions in detailed form and the suggested amendments to the various sections, I think I've covered my time and I thank you very much for your patience in listening to me.

**The Chair:** Thank you very much for the submission and the detail of the recommendations.

**Mr Jim Wilson:** It's really Dr Romans, is it not?

**Dr Romans:** Yes. Not medical, though.

**Mr Jim Wilson:** No, but it's PhD.

**Dr Romans:** I don't want to get myself into—

**Mr Jim Wilson:** You served on the board of governors of the University of Toronto at one time?

**Dr Romans:** Yes. I have worked for the university all my life. I was director of the insulin division at the Connaught lab when I retired. I worked in—

**Mr Jim Wilson:** I served on the board of governors at the same time you did.

**Mrs O'Neill:** You must have changed, but he didn't.

**Mr Jim Wilson:** It really is a few years ago, actually.  
*Interjections.*

**The Chair:** At that time, though, they were his fault, not yours.

**Mr Jim Wilson:** There were 52 of us, so rather a large board.

But clearly a great deal of hard work's been done and you bring to us a number of recommendations. Rather than ask you about that specifically, you know the group before you has suggested that perhaps we're wrong in terms of our opposition to the legislation. Multiservice agencies, according to the senior citizens' consumer alliance, should save at least administrative dollars, which then can be better directed towards front-line services.

I guess the problem I have is that the history of government in this province has shown that the larger the organization and the more centralized, the greater the expense. I think of regional government, which I just went through in my county, and we now have the first deficit in over 100 years; superministries, which all governments across the country have experimented with from time to time, and we end up dissolving them and going back to smaller units; large school boards, and there's a real cry out there now to decentralize them and go smaller.

I just want to know your general feeling about these MSAs, the theory being that if you've got about 1,000 community agencies out there now and you dissolve them all and put them under 40 or 50 or whatever the number will be of MSAs, you should save administrative dollars. To me that flies in the face of the actual history of the

province in our attempt to do that, because we usually end up dissolving community agencies, many of which have volunteer boards and that sort of thing, replacing them with a superministry with several more departments and several more bureaucrats and higher-paid people.

Secondly, we've also been told by the unions that costs will go up because of unionization in the sector. I'm not against unionization, but over half the community-based workers now aren't unionized. If you put them under one roof and combine that with our new labour laws, you have an application very quickly before the labour relations board which will essentially be a rubber stamp.

So if you could deal with that and the costs, because we're now being challenged, as of the last presentation, that our assumptions are wrong, and they've done a study. I note the study doesn't tell us what will happen if donations stop and they don't tell us how they'd replace the monetary value of volunteers in the current system, but that aside, I do challenge the notion that bigger is better and I wonder if you have any comment on it.

**1450**

**Dr Romans:** I obviously don't have time to really consider that, but it seems to me that with the MSAs there's going to be a consolidation of volunteer organizations, and those volunteer organizations at the moment raise a fair bit of the volunteer money which carries the system. I'm not sure, and this is why I emphasize the importance of what's going to happen to volunteers, because I think there's no guarantee at this stage. When a partial function of the voluntary organizations goes to the MSAs, I'm not sure that's a guarantee that the volunteer organizations will have the same ability to raise the same proportion of their expenses that they do now.

That again is off the top of my head. You've asked me a tough question and I don't have the benefit of a financial consultant to back it up. But certainly our feeling is that the MSAs are going to be the driving force and will take a reasonable bit of the money because they're going to do part of the job that's now done by the volunteer organizations.

**Mr Jim Wilson:** You made the comment that the government should provide a cost-benefit analysis prior to third reading. How strongly do you feel about that?

**Dr Romans:** I think our general answer to that is that for this group and the government in general and the other groups who are trying to be helpful, the more precise information we have, the better the chance that we're going to make right decisions, and I think there's no guarantee of that at the moment.

MARLENE MULDOON

**The Chair:** I call on Marlene Muldoon. Ms Muldoon, welcome to the committee. We have a copy of your presentation. Please go ahead.

**Ms Marlene Muldoon:** This opportunity to speak to the standing committee on social development allows me to present a perspective from an individual who works on a daily basis with providers and consumers, and I'll hereby refer to consumers as "clients" in my presentation.

My presentation mainly refers to section 20 of Bill 173, which outlines how a plan of service is devised for

a specific client, and also subsection 20(3), which identifies those who will be involved in the development of this plan of service.

Under plan of service, assessing the person's requirements, determining the person's eligibility for the services that the person requires, and developing a plan of service are responsibilities that the home care case managers are presently doing throughout the province. We refer to these roles as assessment, monitoring, evaluating and improving the quality of services. On the average, using my employer program as an example, a case manager yearly authorizes a quarter of a million dollars in services to home care clients. This translates to \$17 million of services authorized to clients receiving services just within one program in one year by 25 case managers. This is just the example I'm using.

Since the inception of home care programs in 1958, funding for these services has been uncapped, with no awareness on our part of how much money is spent on individual care in clients' homes and how we compare with the rest of the province. In my day-to-day assessments and reassessments, a case manager is often asked by her clients: "Are these hours putting a burden on the program? Am I receiving more or less than others on the program?" Clients are asking for information on what their care is costing the system. They are also asking to be more a part of a cost accountability system of care. What I'm envisioning and recommending here is a more cost-directed care whereby the case manager would closely monitor costs generally and in relation to an average care map for the area and the province.

To elaborate on the care map, a care map is an approach used to coordinate care in some home care programs. It's a standardized plan for clients who need different categories of care. What I am also proposing is a cost care map that would also track the average cost of the care within a certain category. For example, a client is admitted to the home care program for a fractured hip. A cost care map establishes benchmarks for their care, and the client's recovery would be closely monitored and compared to the average cost and activity for that category for the area and the province. This gives the case manager who is monitoring the overall care guidelines in authorizing the client's care and the overall incurring costs.

Case managers generally have the first contact with clients, as we do most of the initial assessments. At the present time, each provider also does his or her own assessment. This creates duplication. To become more cost-effective, a comprehensive universal assessment tool is needed that is layered or sectioned for appropriate providers to use as well. Following the initial assessment using this universal assessment tool, the client and case manager determine what providers are required according to their needs. If only one service is needed, like therapy or nursing, this provider can manage the care with the client or care giver in charge. The case manager who has done the initial assessment need only monitor the overall costs and activity within the client's care. If costs are exceeding the average cost, these circumstances would be documented. This approach achieves more cost

accountability and good-quality management of care within each client's home.

Also, in many situations a client can direct their own care. One example is a situation where there's one monthly visit required, for example, for catheter care. Bill 173 emphasizes tailoring care provision to fit the consumer's need rather than adhering to rigid, inflexible program rules. This modification also allows for a more cost-effective service, so we're certainly endorsing that. Therefore, with a continual, ongoing cost accountability system in place with the client in the forefront, cost containment can indeed be a reality.

In summary, what I'm proposing we need is a client-driven care system based on benchmarks or averages established by cost-care maps for each area; a common database used by all providers which includes cost monitoring or cost analysis; and, third, a universal assessment tool to avoid duplication by case managers and providers.

**The Chair:** Thank you. I note on the front of your submission that you're involved in home care in Grey-Bruce.

**Ms Muldoon:** Yes, I am. I'm a case manager with the Grey Bruce Home Care program.

**The Chair:** We thank you for taking the time to come down before the committee. The parliamentary assistant has a question.

**Mr Wessinger:** Thank you very much for your presentation. It's interesting hearing case managers and what role they play. I think it would be useful to myself and perhaps also useful to members of the committee to understand the extent.

You raised my interest when you mentioned about the need to monitor each individual case by a case manager, and you were referring of course to some of the financial aspect. But what I'd like to sort of explore also is, at present, do case managers continually monitor the care being given to the particular client? Is there a process where they monitor it?

**Ms Muldoon:** Monitor in terms of the type of services?

**Mr Wessinger:** To see how it's working.

**Ms Muldoon:** Yes, we do. We do reassessments every three months for the clients on our chronic care program.

**Mr Wessinger:** In other words, you do an initial assessment and then a reassessment.

**Ms Muldoon:** Yes.

**Mr Wessinger:** Is there direct communication between yourself and people who are providing the service at the present time? Would the person providing a service, if they saw a problem, call you directly?

**Ms Muldoon:** Most definitely. We conduct regular conferences with the providers who are involved with the different clients.

**Mr Wessinger:** So if, for example, a client expressed a wish to change their plan of service with the provider, that provider would then contact you directly?

**Ms Muldoon:** That's right, and then we would discuss the change. It would be with the client as well.

**Mr Wessenger:** Right. And you say that you don't think the present system has enough flexibility with respect to meeting the clients' needs?

**Ms Muldoon:** That's right, because we have mandated standards that we have to do throughout our care loads, so if in some circumstances the provider can manage their own care, I think that would be fairly feasible, if it's just one provider involved with the client. What I'm proposing, then, is that the case manager just overall monitor the costs of that particular—

**Mr Wessenger:** And also give you more flexibility in your—

**Ms Muldoon:** That's right.

**Mr Wessenger:** In other words, if they loosen some of the rules and give you more judgemental flexibility—

**Ms Muldoon:** And we give the provider also the judgement.

1500

ROSALYS LAWRASON

**The Chair:** I call on Rosalys Lawrason.

**Mrs Rosalys Lawrason:** I thank you very much for this opportunity to speak on Bill 173.

I am a consumer, also a care giver, and since 1991 I've followed very closely where I could the progress of the long-term care reform. I've been a member of the consultation advisory group, the city of Toronto working group, I'm currently on a work group steering committee of the district health council and we're working on in-home and community support.

Two years ago I became a member of the board at SPRINT, Senior People's Resources in North Toronto, the agency which provides us with in-home respite care from the Alzheimer dementia program.

I've been caring for my husband for the past eight years. He is cognitively impaired, with very limited physical mobility and other medical conditions. He requires 24-hour supervision and assistance with most aspects of daily living.

My goal has been to keep my husband at home as long as possible. In 1989, I found I could no longer manage alone and my husband was put on the chronic home care program.

I am indeed grateful for all the assistance I've received from Metro home care and many others—I haven't done this alone—and most noticeably the services of the social worker and occupational therapists from Community Occupational Therapists and Associates. The COTA worker has helped me with all the equipment that was needed for safety in the home and arranged for the walker, wheelchair and Wheel-Trans. I would just like to say, about Wheel-Trans, that it has been absolutely marvellous, and we've been on a pre-book system when we go out. The worker also arranged for the adult day program and now continues to assist me with lifting, and when she sees my husband, she comes and does exercises and ambulation with him.

The services of the social worker have been invaluable in assisting me to plan for the future re financial, legal and placement. When she came to us initially, she

encouraged me to look at in-home respite care.

Both professionals, the COTA worker and the social worker, have provided me with so much support and encouragement in my role as a primary care giver. I don't have any of the things everybody wants, like family on hand to come and relieve me and do all these things. I'm alone and I think there are probably others like me.

I now wish to focus on the value and importance of in-home respite care. The workers we have come from SPRINT. They're well-trained, they're supervised and they're dedicated to caring for the elderly and the cognitively impaired. They have demonstrated caring in a caring and empathetic manner. They show respect, understanding and determination to keep my husband functioning at his highest possible level. It's interesting that they view the family as a whole.

One of the most important things to me is that I deal directly with the social worker at SPRINT who makes these bookings that I request. The same workers are assigned, and that has been my salvation, the continuity of care. I'm then free to make plans for activities for myself. Free time for a care giver is essential, and to me it's very precious. It's made possible by these workers to whom I entrust my husband's care in my absence, with the knowledge that he'll be cared for according to his needs and my wishes.

A further advantage to me is that the fee is affordable. SPRINT is subsidized by Community and Social Services and the United Way. I pay \$7.75 an hour versus what I think is the current rate in the community from an agency of \$18 an hour. So it's easy to see, if I'm forced into that sort of situation of a private agency, that my time would be cut in half. I spend approximately \$4,000 a year on respite care and, as I say, I can never leave unless somebody's there in my place.

It's for all these reasons that I suggest in-home respite care be included as a separate entity under both community support services and personal support services. It's truly essential to a care giver and must be affordable and easy to access.

On the access, what I'm trying to get across is that I want to go out when I want to go out and not have a booked time. I can pre-book but things come up, and it's let me lead a more normal life when I can choose when I'll go out. We do have an excellent homemaker. She comes at set hours and she's involved in personal care. I have her eight hours a week and then I use SPRINT on a fixed eight hours a week.

The services listed under "Interpretation" as care giver support services are all valuable. I hope that these services could be made available in the home if necessary. It's unlikely the care giver can afford to pay for respite care to attend an educational series, and these quite often run and may be a series of eight. The other time it would involve a support group. It's hard to plan all those extras.

One suggestion I have as far as the education of a care giver at home is that a professional with psychogeriatric skills in a case like ours be the person assigned to visit on occasion; not always, not often. Another suggestion I

have is possibly a hotline. You do get into trouble and all you need is somebody who can give you probably a simple answer.

I noticed that the adult day programs stand as a separate entity under community support. These programs undoubtedly serve a much-needed purpose and are very useful to many, but they're not always useful in the case of the cognitively impaired. I've found it takes extra effort on my part to have my husband participate in those programs. He did for four years; he can't any more. He's not able to because of fatigue. But in our case, the benefit was really for my husband, not respite to me as the care giver.

There's much in Bill 173 that should be helpful to clients and care givers, but I noticed no reference to client intervention and assistance or case management and I wonder who will assist me in planning, coordinating and evaluating the services I require. I'm sorry to use "I" so much, but it seems I may even be the client.

Under the purposes of the act, where it says "to promote equitable access to community services through the application of consistent eligibility criteria and uniform rules and procedures," this is essential when it comes to accessing personal and professional services. I hope the eligibility criteria will include clients who are cognitively impaired. The frail elderly, there's a lot of stress there, and I think the cognitively impaired are different and their needs are different and the care givers' needs are different, dealing with them. I've found it very difficult at times to prove my need and occasionally I've been asked why I need help. It's because my husband looks well, he's content, he's comfortable in his own home and he may respond appropriately to a simple question.

The 24-hour day and seven-day week is a formidable challenge to a care giver. It's fraught with responsibility, decision-making and often demanding physical work. The emotional and financial drain can be substantial, and much depends on the attitudes of personnel who plan, deliver and evaluate the care for the client and his or her family. It is possible to care for a loved one at home with backup from caring, supportive personnel who truly believe in keeping a client in their home in order to prevent institutionalization.

**Mrs O'Neill:** Thank you very much, Mrs Lawrason, for coming. There haven't been many front-line care givers such as yourself who have been able to present just what's happening there today.

You bring back many memories to me personally in the care of my father, who died in 1993. I am very pleased that you brought forward to people the occupations that helped me immensely and seem to be very much in your basket of supports as well: social workers and occupational therapists. I had never had anything to do with either set of professionals before.

I think you and others who came today, although you more specifically and first hand, are concerned that maybe the professional care part of Bill 173 is left very much in the nebulous realm. We don't know what professionals will be included and whether certain professions will be much more available through certain

MSAs than in others, and how much the ministerial approval will be needed for each of the professions as they come on board.

**1510**

Respite care, you certainly made a case and I'm very pleased that you were as specific as you were. It's certainly helpful to have that kind of knowledge on this committee.

You brought forward something that I think most people who haven't had your experience, indeed a little bit of mine, don't realize: just how difficult it is to first of all diagnose and then come to grips with the psychogeriatric care or the cognitive inability or incapacity of a loved one, because in many cases they can, for maybe an hour or even an evening, "get up" for an occasion, and then that certainly leaves very quickly and may not return for a considerable length of time.

We've had quite a few people express to us that they are quite concerned about that area of care as well, because there is no indication in Bill 173 about mental illness and psychogeriatric care. Will it come at the bottom of the list in the provision of services in MSAs? I don't know.

I think that your presentation has made an impact on all of us. It certainly has on me. I really don't have questions for you. I just want to congratulate you, in your busy and demanding and compassionate role, for taking the time to come and share your firsthand experiences with us.

**Mrs Lawrason:** Thank you.

**The Chair:** Thank you very much. I know what Ms O'Neill has said would convey the feelings of all the committee members. One of the things in hearings such as ours, to have individuals come forward, it is sometimes more difficult to ensure that happens, and so we really appreciate the perspective that you've brought of both caring for your husband and how you organized that and being able to see a real-life story in terms of the whole area of long-term care.

ADVOCACY CENTRE FOR THE ELDERLY

**The Chair:** I call upon the representative for the Advocacy Centre for the Elderly. Welcome to the committee.

**Mr George Monticone:** My name is George Monticone. I'm with the Advocacy Centre for the Elderly. The advocacy centre is a legal clinic for low-income seniors that's funded by the Ontario legal aid plan. We've been in operation now since 1984.

ACE strongly supports the purposes of Bill 173 as they're set out in section 1. In particular, we support the efforts to ensure that a wide range of community services is available to people in their own homes and other non-institutional settings. We also support the effort to improve the quality of community services and to promote the health and wellbeing of persons requiring these services, many of whom will, of course, be elderly persons.

There are many complex economic and administrative issues in connection with Bill 173. In our capacity as a legal clinic, we really are only placed to discuss with you in a meaningful way certain aspects of consumers'

interaction with community-based services. We only hear from people experiencing difficulties, so our comments to you today are based primarily upon our experience with seniors who have had a problem with community-based service.

Before I begin, I would emphasize that every day in this province, hundreds if not thousands of people are assisted in their homes by a vast array of services, from visiting nurses to Meals on Wheels, from attendant care workers to homemakers. The fact that so much of this goes on each day without complaints and without anyone calling us is a testament to the dedication and skill of the many women and men, both paid and volunteer, who are responsible for delivering the services to the community. However, my task today is a less happy one of asking you to turn your attention to the minority of cases where all may not be well and to ask you to consider our recommendations.

The most common kind of complaint we at ACE hear is that the quality of service is not what it should be. Nearly all those who make this complaint to us have modest expectations about quality, but even these modest expectations sometimes are not fulfilled. Many such complaints are heard from seniors who have contacted ACE about something else initially.

Just as some examples, we hear complaints ranging from, "My kitchen isn't cleaned properly," or "They don't understand the kind of food that I normally eat," to "Every time somebody shows up at my door to assist me, something of mine goes missing," and there are complaints about workers showing up late or leaving early and not giving them the requisite amount of time.

These kinds of issues, which I will label quality issues, are extremely important for a number of reasons. Not only are they important because we hear so many of those kinds of complaints, I think they're important because one has to reflect on the nature of these services and realize just how intrusive and personal they are. They're delivered in someone's home, usually out of sight of the public or anyone other than the service provider and the recipient of service. Also, if this were a free market, a dissatisfied customer could simply go elsewhere, but that's not the case. MSAs will be, in many locales, the only option and it's important that this option be of the highest quality.

Because it's an avowed goal of this reform to achieve high quality, and for the reasons just mentioned, ACE is making three recommendations in this area.

First of all, we would ask you to consider including in the bill of rights the right to make a written complaint to an MSA and the right to a timely written response to the substance of that complaint. I think this will help ensure that complaints of this nature are taken seriously, that they're not treated like suggestion box complaints, where someone puts a complaint in a box and it disappears.

A second recommendation is that the quality management system that's required by section 24 should include periodic reviews of all complaints concerning the quality of services.

Thirdly, we would ask you to consider requiring MSAs

to provide an alternate dispute resolution mechanism to deal with the more serious complaints about quality, where this could include something like a referral to an ombudsperson.

We don't have specific recommendations as to what this mechanism should be. We wouldn't even insist that the legislation set out a specific mechanism, but perhaps do no more than to require MSAs to have a mechanism available.

Finally, with respect to quality, to get to the heart of the problem, there's a need for good education and training and decent pay for workers to ensure that they're inspired and able to provide the best-quality service.

A second major source of complaints that we hear about has to do with eligibility. Again I have three recommendations in this area.

First of all, Bill 173 has 42 regulation-making provisions. We believe that too many issues of vital interest to consumers are left to these regulations and therefore will not be the subject of public debate. So we are recommending that Bill 173 deal itself with the issue of eligibility criteria and some of these other issues; in particular, issues about fees, if fees are to be charged, issues concerning limitations on services, termination of services and issues regarding waiting lists. Without knowing any more about these matters than we do right at the moment, consumers don't know what they're supporting or rejecting in supporting or rejecting Bill 173.

#### 1520

Second, with respect to eligibility, we would ask you to consider an amendment to the bill guaranteeing the status quo if someone is appealing a decision regarding termination or change of service. Section 32 of the bill allows for appeals of decisions regarding eligibility or a change in a care plan or a decision regarding termination. That's very good. We support that. But we believe that a person who undertakes such an appeal should continue to receive the services they have been receiving until the appeal is decided, and there's no provision for that in the bill.

Finally, with respect to eligibility, there's a problem regarding termination of services which is so serious we feel that it needs some addressing. Imagine yourself as an individual receiving services from an MSA and your health is declining and you gradually need more and more services. Finally, you're told that you're at the limit, that there is a limit as to how many services can be provided and you've reached that. In fact, you've maybe gone beyond that. Now, in the past it's been known that service providers would at that point say to the client that they are no longer eligible for any services because they require more than it is possible to give them. This, needless to say, precipitates a crisis.

I've dealt personally with clients who, in that situation, are willing to accept the limit and are willing to accept the risk that goes along with not receiving enough service. In those situations we believe it should be possible for that client to receive the service up to the maximum even though they are at risk, assuming that they are willing to accept that risk. We think Bill 173

should be amended to provide for that possibility.

Finally, we're concerned about the bill of rights found in Bill 173. We support the concept of it, but we believe there's no real legal right without a remedy; that if the bill of rights is really giving rights to consumers, there must be a way of enforcing it. Unfortunately, there doesn't appear to be, despite the fact that the bill of rights is deemed to be part of a contract between the service provider and the recipient of services.

We believe that in order to give the consumer some real power, he or she must be able to take an infringement of the bill of rights to the Health Services Appeal Board and that the board must have authority to order the service provider to comply with the bill and/or award damages for infringement, similar to what we find in the Human Rights Code.

One final comment, having to do with the abuse of vulnerable adults: MSA workers will become aware of the unfortunate fact that some people they are providing services to are victims of abuse, and because of their vulnerability, often due to physical illness or infirmity, these people will not be able to deal with the abuse effectively. What should the worker do? The answers are not always easy. It takes patience and sensitivity to deal with these types of problems. The wishes of the vulnerable person must be respected, but steps can be taken to assist people who want assistance.

Therefore, we would recommend that MSAs be required to train workers having substantial contact with clients to enable them to assist abused vulnerable adults who want assistance and to assist them in a respectful and sensitive manner.

**Mr Jim Wilson:** Thank you for your submission indeed. I very much like your definition or parameters surrounding the term "quality." I want to ask you what percentage of complaints that you would hear in your experience stem from not enough money in the system versus the percentage of complaints that are directly tied to a quality issue as you define the term. Just give us a rough outline of your experience.

**Mr Monticone:** I suspect that's a loaded question.

**Mr Jim Wilson:** It isn't.

**Mr Monticone:** Not enough money in the system—

**Mr Jim Wilson:** Your quality definition to me is a little different from going to you and saying, "I couldn't get X-Y service." We went through this on advocacy. We often used to complain, "That's fine, but if the advocate then goes to the administrator of a home or something and says, 'Mrs Jones wants this,' and the administrator says, 'I haven't got any money for that'"—do you know what I mean?

**Mr Monticone:** I would say that far more complaints that we receive have to do with quality than have to do with ability to access the service. But I would hasten to add that I don't know whether anything can be taken from it. The quality issues often, as I have mentioned, come up in the context where a client has contacted us regarding something else entirely and we discover that yes, they're receiving home care or some home services and it comes out that there's a problem with that service.

I wouldn't think that one could draw any particular conclusions from that at all.

**Mr Jim Wilson:** I have to deal with these things as an MPP too and I do draw conclusions on whether it's something wrong in a particular agency, that the workers are unhappy and therefore not necessarily providing the service, or the administrator's a real SOB and that's why the thing isn't being provided, or the fact of the matter is the agency's hands are tied by a higher level, and that is, there's just no money or there is no bed or there is no service available. That's why I asked the question. It wasn't loaded; it's just that I wanted to know what your experience was versus mine.

I want to ask you a supplementary about the bill of rights. You make a very good point that's been made frequently, that the model in the bill right now is a deemed contract, and that certainly isn't clear in reading the legislation. I think of how people would remedy an infringement of the bill of rights. Now you're suggesting that the appeal board's powers be expanded to alleviate the infringement or suggest a remedy. I'm just wondering how strongly you feel about that. You're a good person to ask. You're a lawyer and you're in the business, I think, of ensuring that people's rights are upheld, so help me out here.

**Mr Monticone:** I'd say we feel quite strongly about that. It was a matter that we have dealt with in a different context. As many of you undoubtedly know, there's a bill of rights associated with the Nursing Homes Act. We made the argument when that was introduced that there should be an enforcement mechanism. There isn't. It's still useful to have that bill. People do take these matters seriously because it's there in the legislation, and it's useful for us when we're arguing on behalf of a client in a nursing home to be able to say, "Well, it says in the bill of rights...." I don't think the choice here is no bill of rights or a bill of rights fully enforceable. There is this middle ground.

Having said that, we would certainly prefer to see something more enforceable. I doubt whether there would be very many cases at all that would involve a hearing at a tribunal. In the nature of these kinds of matters, I don't think things would go that far, but it may help a good deal in solving problems that arise that there is that possibility, that it exists and the service provider knows that this person could take that matter to a hearing. That would assist us a great deal. I think we would solve virtually every problem with that as the background.

**The Chair:** Thank you very much for coming before the committee with that particular perspective. It's very helpful.

1530

#### UNITED WAY OF PEEL REGION

**The Chair:** I call upon the representatives from the United Way of Peel Region. I want to thank you for coming over today to appear before the committee.

**Mr Rav Grover:** Thank you, Mr Beer, and thank you members of the committee. I am Rav Grover, president of the board of directors for the United Way of Peel Region, and with me today are Roy Spooner, executive

director, and Sally Pincock, United Way agency staff.

The United Way of Peel Region is a not-for-profit agency which serves the municipalities of Caledon, Brampton and Mississauga, located west of Toronto. We currently provide \$4.6 million, which we raise in the community, to 45 agencies providing health and social services to Peel residents. Fourteen of our funded agencies, with a total allocation from the United Way of \$1.1 million, will be impacted by proposed changes to the long-term care service system. Their clients will be affected as well.

The region of Peel, with a population of 784,000, is the second-largest region in Ontario and is experiencing huge population growth. The population is projected to surpass one million by the year 2011. Peel is a major reception area for newcomers to Canada, making it extremely diverse culturally, racially and linguistically. Seniors and persons with disabilities are a rapidly growing group in the region. As a result of this growth, the expansion of long-term care services, both community-based and institutional, is an urgent need. These services in Peel must be accessible to consumers in terms of geography, language and cultural appropriateness.

The objectives of the legislation as described in Bill 173 are not new ones. Community-based, consumer-focused, accountable, accessible services currently exist in the community agencies providing long-term care services. These same criteria are integral parts of the United Way's agency review process to ensure donor dollars are well spent in Peel.

It is, however, important that United Way maintain a separate decision-making process about its allocation so that it can fulfil its stewardship obligations to its donors. Therefore, the board passed the following motion in December 1993:

"That the United Way of Peel Region reserves the right to re-examine, in consultation with member agencies, the agency funding levels in light of any changes in finances or services due to long-term care reform."

The board also wrote to the Honourable Ruth Grier, Minister of Health, on January 5, 1994, informing her of the motion, and I quote from our letter:

"...expressing great concern that the guidelines appears to eliminate the option of the MSA choosing a brokerage model, as opposed to a direct service delivery model. This is a fundamental issue. We urge you to allow the local long-term care advisory committees to have autonomy to choose the most effective model for local conditions."

United Way of Peel is participating actively in the long-term care planning process in Peel and is participating as one of six selected sites across the province in the United Ways of Ontario direct service volunteer research project. Our goal is to work with the community to develop the long-term care service system which will best serve the residents of Peel.

The United Way of Peel Region strongly supports the broad goals of the reform as described in Bill 173, particularly local, community-controlled planning through

district health councils. We do, however, have several concerns about the draft legislation which we will share with you today. We have brought copies of our position paper for each of you, which I believe you all have.

Our first concern is, Bill 173 provides a cookie-cutter approach to service delivery. The draft legislation assumes that the MSA's integrated model of service delivery is the best answer, indeed the only answer, to improving long-term care service delivery. It requires that the MSA be the major, if not sole, service provider. This is not an acceptable approach from our viewpoint. We challenge this assumption and ask the minister to provide for us and indeed for all Ontarians the research and evaluative data which support integrated service delivery in any sector as a proven method for improving service for consumers.

We suggest that there is no conclusive data and that the establishment of MSAs as described in draft legislation may not result in better services for seniors and people with disabilities.

The MSA model is so prescriptive in its approach that it undermines the potential for sound planning by local communities. District health councils were given the lead role in the planning for improved service delivery while containing administrative costs, but the draft legislation precludes local planning from having an impact on the local model of service delivery.

The Peel District Health Council, with the help of community partners like United Way, has developed and is proceeding with a comprehensive local planning process. We are gathering information from relevant sources about the existing system in Peel, what is working and what is not. Broad community input will continue to be solicited at appropriate times in the planning process. Predetermining the outcome of effective local planning by legislating the MSA model as the end result is subverting the development of a local system which will truly serve consumers better in our community.

Integrated service delivery and the MSA model, as described in Bill 173, represent a drastic change from the service coordination agency described in the government's consultation document in 1992. In Peel, there was widespread support for one-stop access for consumers and for enhanced service coordination. Both of these goals are strongly supported by the United Way of Peel Region. However, major restructuring of independent agencies to create new service delivery agencies was not a recommendation of Peel residents. Therefore, we recommend that the legislation be amended to allow more flexibility in the model of service delivery as determined by local planning.

A second concern is that in addition to objecting to the mandated MSA design, we are concerned about the 20% budgetary limit on purchased services. We question how this figure was determined and what the implications are if MSAs have reached the 20% limit at the end of the four-year period as set out in the legislation. Therefore, we recommend that the 20% limit on purchased services be removed from Bill 173 and that more flexibility be delegated to local communities in this area.

Our third concern is that the MSA described in Bill

173 will eliminate choice for long-term care consumers. MSAs, which will be heavily regulated, will be the only affordable provider of most long-term care services. We acknowledge that consumers with complaints may access an appeal process, but we fear that lengthy delays in service may result. We are concerned that a monopoly on service delivery may minimize the MSA's attention to quality assurance and customer satisfaction.

In Peel, we currently have a system where different service providers can be accessed through home care or directly by consumers. We see this as managed competition which results in high-quality services and customer satisfaction and will assure communities of high-quality, cost-effective care. Therefore, we recommend that a system of managed competition is the best option for consumers.

Our fourth concern: We are concerned that the MSA will create an unnecessary bureaucracy and that the implementation of such a radical restructuring will be costly to Ontario taxpayers. We are not aware of any cost benefit analysis to support the notion that cost savings will be achieved through streamlining administration, other than the one we acknowledged in the newspaper this morning.

The United Way of Peel Region is knowledgeable about many of the agencies providing long-term care services, due to our thorough agency review process. We know that most community services are currently delivered in an effective and cost-efficient manner. We also believe that our local planning process is intent on achieving efficiencies where it is feasible. A costly restructuring of the entire system is not, in our opinion, the best way to achieve economies. We recommend, therefore, that a cost-benefit analysis of the impact of Bill 173 be carried out by the government and be made available to the citizens of Ontario before this legislation becomes law.

Our fifth concern: We are concerned that the funding envelope described in Bill 173 may result in an actual cap on service availability. From the outset, United Way of Peel Region has recognized that a reformed long-term care system will only be successful if adequate funding to provide an acceptable level of service is provided. The Fair Share For Peel Task Force and the region of Peel have identified a significant underfunding of services for seniors, and indeed all citizens of Peel. It would be impossible for services in Peel to fulfil the obligation of the legislation with current funding. An integrated service delivery model may put at risk the significant funding that existing agencies currently raise independently to support long-term care services.

#### 1540

Bill 173 presents an uncertain approach to funding and potentially puts the MSAs in the untenable position of being required to deliver certain services with no guaranteed funding. The proposed legislation says that the MSA "shall" provide services whereas the minister "may" provide financial assistance. The legislation does not put the same onus of responsibility on the government as it does on the MSA.

Therefore, we recommend that adequate funding for an

acceptable level of service be a priority for any reform to long-term care community services and that the language of the bill reflect the province's obligation to fully fund mandated services.

Our sixth concern: MSAs may result in consumers waiting longer for community services than is the case today. Consumers' needs for long-term care services must be met as quickly as possible. A client-focused system would place the highest priority possible on prompt and appropriate response. This is a strong value for the United Way in determining which services will receive funding. It must not be endangered by unnecessary red tape and paperwork.

In a previous presentation to this committee, a Peel geriatrician expressed her concern about a lengthy assessment tool under development by the ministry. Currently, with one phone call, a physician can initiate in-home service for an elderly patient within 24 hours. Can we be sure that the MSA will maintain the same timely response to consumers' needs?

Therefore, our recommendation is that the legislation be amended to reflect the highest priority for prompt and appropriate response to consumers' service needs.

Our seventh concern: The legislation must respect the major role played by direct service volunteers in the existing long-term care system. According to a survey of long-term care service providers in Peel conducted by the long-term care advisory committee, there are approximately 2,700 volunteers currently working with Peel agencies to provide long-term care services, administrative support, fund-raising or governance.

At United Way, we have a long history of volunteerism. We know from experience that individuals usually volunteer for an organization because they identify closely with the mission and culture of a particular agency. MSAs, as described in Bill 173, will be heavily regulated by government. If MSAs are perceived to be government-controlled bureaucracies, retaining and recruiting committed volunteers will present a huge challenge for the system.

In Peel, as we grow, we urgently need to expand and enhance volunteer services for seniors and people with disabilities. We cannot afford to risk the erosion of this force which is so vital to the current system.

The report from the United Ways of Ontario direct service volunteer research project will be helpful to the ministry in understanding the issues for volunteers working in MSAs. We recommend that the ministry give particular attention to the retention and recruitment of direct service volunteers in the long-term care system.

Our eighth concern: The United Way of Peel Region supports the goal of Bill 173 in achieving easier access to long-term care service for consumers. We believe that a system with one-phone-number access to an up-to-date, comprehensive information database is highly desirable and is achievable in a cost-effective manner through the use of modern technology. We question why the government's work on such an information system is just beginning now. We suggest that an effective and comprehensive information system could achieve improved

access for consumers much more quickly and economically than drastic restructuring and the creation of MSAs as described in Bill 173.

We recommend that an effective and comprehensive computerized system be recognized as an essential component of improving access in services for seniors and people with disabilities.

Our ninth concern: United Way of Peel Region supports the composition of MSA boards of directors as described in Bill 173. We question, however, how these boards will be formed and how they will be evaluated. Will boards be elected, and if so, by whom? How will the minister evaluate boards to ensure that they truly reflect communities they serve and that they have appropriate input from consumers? Undoubtedly, some of these questions will be clearer after the regulations are written. We suggest that these issues are critical to the success of an MSA, and we recommend that the legislation specify that the governance of the MSA be clearly accountable to its community.

In summary, the United Way of Peel Region recommends that communities be allowed to pursue their local planning processes and they be empowered to develop effective, efficient, client-centred services which are most appropriate for local conditions. We urge you to amend the legislation to allow for the option of service coordination in addition to service integration.

Thank you very much for allowing us to present today. We sincerely hope that you will give serious consideration to our concerns and our recommendations for amendments to Bill 173.

**Ms Carter:** Thank you very much. I wish you had been here this morning, when we had a presentation from the Senior Citizens' Consumer Alliance for Long-Term Care Reform. There is an article in the Star today which summarizes what they are saying. Of course you are asking for a cost-benefit analysis, and this is exactly what this group has done. They employed Price Waterhouse, which decided that moving to a system of one-stop shopping would save millions of dollars in administration costs and also shows that the integration that we're looking at under Bill 173, as opposed to a brokerage model, is going to be much more efficient and a cost saving.

It says, "About 30% of the cost of providing services to seniors such as Meals on Wheels, home nursing and homemaking is spent on administration.

"But if those single-service agencies were amalgamated into 'multiservice' agencies, each run by one management team, administrative overhead could be cut in half to about 16%, the study, by accounting firm Price Waterhouse, shows.

"As a result, the money that goes toward direct service to seniors could be increased by almost 26%, to \$439 million from \$347 million, according to the study."

I just wonder what your comments on that are.

**Mr Grover:** We became aware of that article and that study this morning as well. Based on our preliminary research that we then conducted on our own figures through our own agencies that we fund through the

United Way, we determined that total administration costs on the four package agencies were \$518,000; total budgets of \$6,984,000, which represents a 7.4% admin cost. So that led us to be a little sceptical of the figures that Price Waterhouse is quoting. We would love to see that study and have it available for use.

What I further want to add to that is that if I go to my business background, I can see from the way the business environment works that a monopoly is never the most efficient and effective way of delivering goods; managed competition always seems to drive other agencies to compete with each other to be more effective than any other agency to compete for dollars. That leads us to believe that managed competition is a much better approach than monopoly.

**Ms Carter:** I must say that I personally have a profound philosophical disagreement with you there. I think that is fine when it comes to providing goods and other things, but I think for essentials like health care and education, we need something much more—"dedicated" I think is the word.

But certainly you're talking, as we all are, about efficient and integrated service, and this group is saying, and I agree with them, that when you have everything integrated and one access point and everybody is, as it were, communicating closely because they're in the same organization, you are going to end up with more effective and appropriate care.

**Mr Grover:** I agree. I don't want to argue philosophies either at this point, but when we look at integrated services versus if you want to think of them as specialty shops, my experience has always been that integrated service does not necessarily provide the better route to being able to service customers' needs to their satisfaction. When you deal in specialty shops, for example, if you look at the basket of services provided under an MSA, I don't see how Meals on Wheels is related in any way or can provide any efficiencies when it comes to nursing attendants and so on. So when you're talking about services that are different in that sense, I don't see the cost savings that are achievable on an integrated basis when you try to integrate the two.

**Ms Carter:** I guess it's at the administrative level that you would have those.

Now, another point you raise is the question of volunteerism, which we've heard a great deal about, and again the Senior Citizens' Consumer Alliance for Long-Term Care Reform, which presented this morning, had something to say on that. Of course nobody knows exactly what's going to happen as far as this goes, but they see no reason why the system we're now looking at would not in fact provide more encouragement rather than less for volunteers to come forward, because you do have a community-based organization, it's community driven and, as they put it, you have more services to volunteer for.

Presumably, the main concern of a volunteer is the person they are serving, the clients, the people with whatever problem it is that they're helping to solve. To have a specific label attached to how you're providing that service really doesn't seem to be a very large part of

it. So they are certainly suggesting that we could be looking at a plus rather than a minus here.

I believe United Ways are actually meeting with the ministry and district health councils and having forums to make sure that everything is going to be done as this legislation comes into effect to make sure that volunteers remain. We know that it's not going to be an overnight change; it's going to be gradual. So hopefully as these organizations come together the volunteers will be included in that coming together and they will stay with it.

**Mr Grover:** Can I ask Sally to respond to that question.

**Ms Sally Pincock:** We are indeed one of the six sites across the province participating in the direct service volunteer research project which the Ministry of Health has funded through United Ways of Ontario; a small bit of funding, but we're managing. We'll have two focus groups in Peel. Our reading of the terms of reference of that project is that we really want to hear the perspective of volunteers who are doing the work. I think it's a very important perspective, and unfortunately it's been somewhat ignored. Although it's mentioned in Bill 173, it's a very brief mention. We are really urging that the minister will take the report out of this research and read it very carefully.

1550

I can't share your opinion that volunteers are going to be more ready to volunteer. When I look at Peel agencies like Caledon Meals on Wheels—the most dedicated community volunteers, covering a huge geographic part of the region; they go out there in rain and snow and sleet—or the Hospice of Peel, where the whole service is provided by trained volunteers to people where there's someone in the family who's dying, I'm not sure how much they want to be part of a larger, much more administrative structure. I think it's a very big issue.

**Ms Carter:** Well, I see that we're getting rid of administration rather than producing it.

**Ms Pincock:** Our administration costs in the four agencies where we gathered the information quickly this morning are 7.4% of their total budget. It is not 30%, as the Price Waterhouse study indicated, and it's well below the 16% that MSAs apparently will achieve. I think you need to do a bit more research.

**Ms Carter:** Just one more point: I just put it to you that the MSAs in many ways will resemble a hospital. If you're talking about monolithic organizations, you're talking about volunteers not being interested and so on, I know certainly in my own community, where we have two hospitals, both enjoy very wide volunteer support. The community interest in them is very high indeed. I think that an MSA is, as I say, similar in many ways, and I see no reason why it wouldn't earn the same kind of support in the community.

**Ms Pincock:** If I may just respond, I agree with you. Hospitals depend heavily, the three hospitals in Peel certainly, on a very strong volunteer component. I would just suggest to you that volunteers volunteer for different services for different reasons. I'm not sure that I would like to see MSAs quite the same as a hospital, because it

has a very institutional appearance. So I'm questioning some of your assumption there.

**The Chair:** Thank you very much for coming before the committee. I would just note, in case all members didn't, that you also provided us with a response to the Toronto Star article and the article. Just for the record, it is there as well.

ONTARIO COMMUNITY SUPPORT ASSOCIATION,  
AREA 7, METROPOLITAN TORONTO

**The Chair:** Could I then call upon the representatives from the Ontario Community Support Association, Area 7, Metropolitan Toronto.

**Mr Bau St-Cyr:** My name is Bau St-Cyr. I am chair of the Metro chapter of the Ontario Community Support Association, and I'm here today with other representatives from our area executive. Jerry Berman is our vice-chair. Beside Mr Berman is Linda Luste, beside Linda is Catherine Brookman and to my right is Jean Green.

The Ontario Community Support Association is an organization of direct providers of community-based services whose primary purpose is to support, promote and represent the interests of community-based, not-for-profit health and social service agencies across the province.

The following services are provided by our member agencies: Meals on Wheels, congregate dining, home help, homemaking, home maintenance, respite care, inter-generational programs, Alzheimer day programs, senior day programs, friendly visiting, transportation, telephone reassurance, client intervention and assistance, as well as information and referral services.

The Metro Toronto chapter of OCSA, one of 15 chapters in the province, represents over 45 agencies which provide a variety of in-home and community support services for seniors and persons with disabilities. Metro chapter members have been active in a number of initiatives related to long-term care reform, including consultations on policy developments, conducting focus groups on surveys and staffing provincial and local committees. In addition, OCSA members have affiliations with other associations which are also addressing long-term care reform. These networks reflect the different communities to which members belong: geographical, community of interests and/or community of common bond.

We will now discuss the issues related to Bill 173 that are of greatest concern to the members of our area chapter. Jean Green will discuss issue 1.

**Ms Jean Green:** The absence of mention of the client intervention and assistance program in the legislation is highly problematic. This program, funded by the long-term care division for many years, was pioneered and evolved in Metro Toronto. It is considered a vital component in linking seniors with the systems that provide them with resources, services and opportunities, thus allowing them to remain living as independently as possible in the community.

The program provides intensive case management to persons who have complex needs due to a combination of factors such as physical frailty, mental confusion and minimal supports from family and friends. The program

encompasses intake, assessment, service planning, follow-up, support counselling, information and referral, advocacy, documentation, housing and placements, emergency assistance and care giver support.

Client intervention staff work extensively with their clients and are available to assist them in negotiating their way through the system. We cannot overemphasize the importance of the role played by this program in the current scheme of community support in Metro Toronto. To omit this program from the reform would remove a key support element for consumers.

Our recommendation is that a client intervention and assistance type of program be listed as a mandatory in-basket service.

**Mr Jerry Berman:** Issue 2: We are concerned that currently funded programs find themselves divided in the legislation into homemaking, personal support, community support services and professional support services sections. We feel that this breakdown is unnecessary and will only serve to confuse matters further for the consumer. It is imperative that we seek to eliminate barriers to services and provide more integrated care in order to simplify the delivery system as much as possible. Of course, one of the chief problems with the present system is its confusion to the consumer.

We recommend that the artificial distinctions between services be removed from the legislation.

Recommendation 2: that mandatory and non-mandatory programs be identified through a consultation process which would include the provincial body of the Ontario Community Support Association, and that these services then be listed specifically in the legislation.

1600

**Ms Linda Luste:** Issue 3: We are also concerned that most important issues related to the functioning of the MSA will be decided by regulation. We would be distressed to find MSAs become too highly regulated. Presently, community support agencies work through a community development approach and undue rules and regulations would destroy the ability to deal with the unique problems of individuals. We would accept the need for regulations around basic standards, access, provision of the entire basket of services as well as fees, but believe that individual MSAs should develop their own policies and procedures which can then be audited by the government.

Our recommendations would be in this area, that the provincial body of OCSA continue to be invited to have a role in the drafting of regulations, and that individual MSAs be given enough autonomy within the framework laid out by the government to respond to local community needs by developing policies and procedures best suited to their environment.

**Mr St-Cyr:** I'll deal with issue 4. We're concerned that the role of in-home respite care is very unclear in the legislation. It is included in the definition of care giver support services in subsection 2(1), but is not defined or listed as a separate program area in subsection 2(4).

Respite care is a vital service whose mandate is to provide support and relief to care giving families. The

program is complementary to other care giver support programs such as adult day programs and needs to be recognized as a specific program area and funded as such. The aims of the reform can only truly be attained if these types of programs are readily available to families who are providing care giving duties, who are working as care givers 24 hours a day with a service recipient. Thus, our recommendation is that in-home respite care be listed as a mandatory in-basket service.

**Ms Catherine Brookman:** I'll deal with the fifth and final issue, and that is in relation to the bill of rights, subsection 3(1). It reads at present: "A service provider shall ensure that the following rights of persons receiving community services from the service provider are fully respected and promoted."

We are concerned that the wording of this article does not reflect the essential right of all individuals to access service. The right of an individual related to Bill 173 should commence prior to receiving assistance from the MSA, with the guarantee that the service will be available when and as needed.

With Bill 101 and the emphasis on the deinstitutionalization of our elderly population, let us be sure that the bill of rights guarantees access and availability to community services. We do not want to create a system that enlarges our waiting list while consumers go without needed assistance.

One of the principles of long-term care, as spelled out on page 3 of the Community-Based Services Provided by Multiservice Agencies document, specifies that the reform is intended to respect and support people's desire to be healthy and independent. The bill of rights, in its current form, does not support this principle. Therefore, our recommendation is that the wording of this article be changed to reflect the rights of all individuals to receive services when and as needed.

**Mr St-Cyr:** We thank you very much for having given us the opportunity to come before you today to discuss these issues and wish you well in your continued efforts at improving Ontario's long-term care system. Of course, we're available for questions.

**The Chair:** We are now running a little bit ahead of ourselves so there may be the opportunity for more than one question. The next couple of presenters are not here yet.

**Mrs O'Neill:** I'm pleased that you brought forward the respite care. As you know, we had an individual, Ms Lawrason, this afternoon—maybe you were here for her presentation—who first hand explained to us just how important that respite care is to her. We haven't had a lot of that personal witnessing, and you certainly seem to have a sensitivity to that.

I'm going to ask the parliamentary assistant what he can offer as a guarantee to you within Bill 173 that respite care is indeed not forgotten. I, like you, would like to see it more heavily emphasized or highlighted, but maybe there's something he can say that we can get some comfort from.

**Mr Wessinger:** There certainly is a provision in the definition, I believe in care giver support, that respite care

is included in that definition; so it definitely is included in the bill.

**Mrs O'Neill:** Could you be specific with the section? These people certainly know the bill. If you could be very specific, I think it would be helpful to the presenters.

**Mr Wessenger:** Subsection 2(4) indicates "care giver support services." Then if you look at the definition of "care giver support services" under subsection 2(1):

"'care giver support services' means counselling, training, visiting and providing information, respite and other assistance to caregivers...."

I understand maybe the concern is that respite is a very broad term and of course it would include both in-home services as well as other alternatives. So it's a broad term. There's certainly the intention that respite would include in-home respite services.

**Mr Quirt:** Just to add to what Mr Wessenger has said, I think the presenters would agree with me that providing in-home respite to care givers can be done in a number of forms. It may take the form of a volunteer visitor and you may call that your friendly visiting program, but in effect someone may come and visit for a while and allow a care giver to go shopping or go to a movie. Often a homemaker might be a more appropriate worker to send in for respite purposes if there are particular personal care activities that need to be done or if there are particular jobs around the home that need to be looked after. Sometimes if a client's circumstances are complicated from a health perspective, a nurse is the best respite worker to provide.

So we see respite in the new system as a very legitimate and important reason to use all our resources in the multiservice agency and not to limit it to one particular category of worker. If there's a way that we can convey that in a more complete way in the act, we'd be interested in your suggestions on how we might do that.

**Mr St-Cyr:** One of our concerns is that many of the services that are presently provided in the community sector are listed in the legislation, where a service such as respite care is not. The type of service Mrs Lawrason, the care giver who came earlier, discussed with you is an in-home-type respite care service that is coming in to provide her with a set number of hours of relief every week. That is the type of funded respite care service in Metro Toronto and the one that exists presently. So we're concerned that that type of program doesn't come back specifically listed in the legislation. Although we understand that a large part of the intent of the legislation is to provide support to care givers, we would feel quite a lot more comfortable if that particular program that currently exists and is so effective in relieving families, such as the one of the care giver who was here earlier, was in fact listed in the legislation specifically.

**Mrs O'Neill:** I want to go to the bill of rights, because that's been brought to us a couple of times as poignantly as you have presented it, and I think you've hit the nail on the head. We have here access but it's access to access, not access to service, and I'm really pleased that you mentioned the waiting lists. We haven't

got the guarantees to service built in here. In fact, it makes me quite nervous that waiting lists are given a profile in the legislation, because, not particularly in Metro Toronto but in other areas, particularly small areas, we've been told there really are no waiting lists at the present time and that they do seem to have the complement of staff they need and the combination of staff they need to serve their clients.

So I wondered if you want to say a little bit about how you think that bill of rights could be changed, or am I interpreting what your concerns are correctly, is also important.

**Ms Brookman:** Thank you for your comments. In terms of the waiting lists, just to speak to that, I think you're correct in suggesting that many agencies do not have waiting lists, and the reason that they don't have waiting lists is because we don't want to give clients false hopes. We don't foresee the availability of resources to service the clients; therefore, we're not putting them on a waiting list for particular services. Therefore, clients once again are out in the community shopping around.

1610

With respect to long-term care reform and enlarging service, there may be a possibility of putting people on waiting lists, but that would only be possible if in fact we had the resources to accommodate that.

In terms of the bill of rights as it is written right now, it talks about the rights of persons "receiving" the community services, so the person is already in the system. But the difficulty and one of the major rationales for the reform is prior to receiving service. That's what we want to do something about. We want to open up access. We want to let people know where they can go for help. We want to improve the image of the government in terms of long-term care reform and how we care for individuals. That's why we specified that the wording needs to reflect not only the rights of individuals receiving service, but we have to pay attention to the rights of individuals prior to coming into receiving community services.

**Mrs O'Neill:** Thank you very much for your comments. I found them helpful. I too don't think we should be building unavailable expectations and we shouldn't be using a lot of nice, fuzzy words that really we have to take a leap of faith on. So I'm pleased that you were as specific as you were in the points and your concerns.

**Mr Tilson:** I'd like to speak to your third issue, which is the issue of regulations and your fear of an overregulated organization or service.

I was interested in the vast number of groups that participate from your member agencies; it's quite an impressive list. I have spoken to some of them, and some of them fear for their existence, in fact, after this legislation, for different reasons. Many groups have come to this committee, and have spoken to members of the Legislature privately, that feel that a balanced home care system would be best provided with private, non-profit organizations as opposed to the type of system that seems to be proposed; that that's the best way to ensure highest levels.

I too agree with your concerns expressed in issue 3, which says that you're really afraid that the whole system's going to become too regulated, too much bureaucracy, that we're going to sink in mounds of paper, most of which no one will understand. Notwithstanding all that I've said, has the government expressed any indication that it would support the recommendations that you've put forward, any members of the government or any members of the ministry?

**Mr St-Cyr:** It's my belief that the government has mandated the district health councils to set up a community planning process. Our concern around the overregulation of the MSA is twofold.

**Mr Tilson:** If I could just interrupt you, I'm thinking specifically with the drafting of the regulations, because I agree with you: that's where all the monstrous horror stories are going to occur. I guess my question is, directly, do you feel that the government will allow you to participate in that?

**Mr St-Cyr:** The legislation is both very specific in some areas, such as a description of homemaking and cleaning services, and very vague in a number of other areas, and that's a bit of a concern. Both of those are concerns.

We understand there are going to be up to 42 regulations that are basically going to put the meat on the skeleton of the MSA. On the one hand, we want to avoid overregulation of the MSA. On the other hand, if we're going to be operating by regulation, we would like the Ontario Community Support Association, a provincial body, involved. Thus far, the process has allowed OCSA to be part, in that our membership is involved in the creation of service standards for a variety of the programs that are going to be offered in the basket of services in the MSA.

Thus far we are involved, and our recommendation basically is that we'd like to continue to be involved. We're concerned about overregulation and we'd like to be in on the setting of the regulation in order to avoid some of the pitfalls. Thus far we've had the in, and we'd like to continue to be part of that process.

**Mr Tilson:** Let's ask them. Mr Wessinger, are you going to allow the OCSA to continue to be part of the process—

**Mr Wessinger:** I'll give my assurance we'll continue to involve them in this process, and we're very pleased to have their participation today.

**Mr St-Cyr:** Thank you. We appreciate that.

**Mr Jim Wilson:** You can take that to the bank.

**Mr Malkowski:** Thank you for your presentation today. You mentioned some of the issues, client intervention and assistance and their programs and that they need to be listed within the legislation. May I ask the parliamentary assistant then, do you think that an amendment may be coming forward to see that this kind of service is listed as mandatory?

**Mr Wessinger:** I'm going to ask the policy person to answer your question, Mr Malkowski. There's no question that these types of client intervention services, which they define as case management services, it is certainly

the intention to continue them. I believe they are covered in the legislation, but I'll ask Mr Quirt to give further clarification on that.

**Mr Quirt:** Clearly, the type of services described, the client intervention and assistance activity that some home support agencies in Metro Toronto are involved in and other agencies are involved in province-wide, is a necessary, important part of the system. We've been funding it for years, so it would be a little silly of us to say it's not a good idea at this point.

Our problem in describing and putting a definition to some of these services is that the wording we use may imply things that others would construe as not beneficial. For example, we've heard presenters before the committee come and tell us how the case management approach of home care is totally inappropriate for the delivery of support services like Meals on Wheels and transportation and friendly visits. So if we were to enshrine case management, we'd have to do it in a way that didn't offend those who were concerned with what's implied with that language.

Clearly, case management—small c, small m—is an absolutely necessary part of understanding a client's needs and situation and how best to serve them and doing it quickly. Making the appropriate arrangements in a crisis situation is a really good example of how that can help someone respond to a problem and not become more reliant on the long-term care system in the longer term. If we can describe case management—small c, small m—including case management and the client intervention and assistance emergency mode, then it's an expectation of ours. It's how we describe it as a service and where we put it in the legislation.

The same thing applies with respite care. We wouldn't want to have people say, "Oh, I guess I got to send the nurse in and the respite worker" because somebody needs to go shopping. We'll send the nurse in. We achieve our respite objective, and if that's the right worker to provide the respite, that's fine. We want to be sure that we don't confuse the objectives of delivering service with the categories of workers. So in both cases we'd be welcoming recommendations on how we can get that message across without implying an overregulation and overspecification of the system that our presenters have had a difficulty with.

I would take the opportunity to say, if you're comfortable with regulations around standards, access, provision of the entire basket of services as well as charges, I can't think of a category where we'd be interested in a regulation that isn't listed there. So we'd be happy to discuss with you what we shouldn't be regulating and we have the forum available to do that.

**Ms Green:** I just want to clarify. I think sometimes when we present, it sounds like we're presenting a program. I want to remind everybody that really what we're talking about is a very vulnerable group of people, and they're not easy to serve. I think our fear is that this will just melt into everything else, and if given a choice, these situations won't get dealt with, because they're complex. They're difficult. People are fearful. People are resistant. So I guess what we're urging for is a recogni-

tion, because without that name in there or that word in there, then to carry out the functions will be extremely difficult. It will get lost.

1620

**Mr Malkowski:** I want to say thank you very much for your very, very valid contribution to our deliberations, and I'm sure with your feedback amendments will be coming forward and we'll see some of this guaranteed.

**The Chair:** Thank you all very much for coming before the committee this afternoon.

Members of the committee, you will see on your schedule that Mr John Muirhead, the past president of the ALS Society of Ontario, is to come before us. He will. He has had a problem with transportation and has called in. I'm going to suggest that we take a 10-minute recess and reconvene at 4:30.

*The committee recessed from 1621 to 1633.*

ONTARIO ADVISORY COUNCIL ON  
MULTICULTURALISM AND CITIZENSHIP

ONTARIO ADVISORY COUNCIL  
FOR DISABILITY ISSUES

ONTARIO ADVISORY COUNCIL  
ON SENIOR CITIZENS

**The Chair:** I'd like to invite the two chairs and one vice-president from the three advisory councils, the Ontario Advisory Council for Disability Issues, the Ontario Advisory Council on Multiculturalism and Citizenship and the Ontario Advisory Council on Senior Citizens. We welcome you all to the committee, and we have a copy of your joint submission. Perhaps I could ask each of you just to introduce yourself for Hansard and for committee members, and then please go ahead with your submission.

**Ms Mary Szkambara:** My name is Mary Szkambara. I'm the vice-president of the Ontario Advisory Council on Multiculturalism and Citizenship.

**Dr Shirley Van Hoof:** I'm Dr Shirley Van Hoof, chairman of the Ontario Advisory Council for Disability Issues.

**Mr Bill Hughes:** I'm Bill Hughes, chairman of the Ontario Advisory Council on Senior Citizens, and glad to be here.

**Ms Szkambara:** First of all, I would like to express our thanks for the opportunity for us to be able to present our points of view on the long-term care. The three councils have submitted their briefs in previous times, and we're just here to reiterate some of the important aspects of the brief and to present some of the issues which are of concern to us.

We were exceedingly glad to hear that this bill is to be consumer-oriented; it is directed to the consumer. However, upon reading the bill, we found that issues involving the consumer were always placed at the end of the points and we found that more focus, and primary focus, was spent on the function and power of the agencies instead of the consumer.

I feel it's extremely important and it should be stated that the consumer is responsible for planning and revising the service plans, unless of course the consumer is unwilling or not able to do so, and then we have other

sources in the government which can guarantee his rights.

We believe that the long-term care should be consumer-oriented, representative of the neighbourhood and community-driven in all aspects, be it in planning the services, prioritizing, quality, monitoring or budget. However, as described in this legislation, it is not, and we are quite concerned, because we feel that as time goes by, the organizations, professionals and special-interest groups might take over the system and we are exceedingly afraid that if there's nobody to be a watchdog or vigilant over the consumer issues, the consumer will be presented with another bureaucratic layer and will have difficulty in attaining any services.

We are exceedingly concerned about the insufficient emphasis that's given to the information so that it can be culturally sensitive and accessible to the ethnocultural community of Toronto. We feel that this information and services must be provided in appropriate language to facilitate the linguistic and cultural makeup of our community.

One of our major concerns that this bill presents is the makeup of the MSAs. According to the bill, the MSAs will be geographically allocated, and in many areas we feel that this might create a problem, especially to our ethnocultural community. We recommend that satellite MSAs be established which would meet the needs of the ethnocultural community, and also any other special needs that might arise.

We feel that if this new system will be in effect, it will create an MSA monopoly of service provisions, and it is inevitable that in spite of efforts to guarantee consumer mechanisms to raise concerns of recommended changes, there will be reluctance to do so because there is no other alternative. We are very, very concerned about the function of the MSAs if there is no other alternative.

We had difficulty in evaluating many components of this bill without the regulations. We feel that regulations must clearly describe and clarify how the process will work, and without the regulations, we find that it's very difficult to evaluate how this process of long-term care will work. When the regulations are going to be made up, we hope the consumer will be consulted. We hope the advisory councils will be consulted. We would like to be involved in all facets in the development of regulations.

Once again, I would like to say that we uphold the principles of Bill 173. We find that there are many good points in it. Our main concern is, we hope that this bill will be consumer-oriented, consumer-directed and that the consumer will be able to understand all facets of this bill, that there will be linguistic translations, that there will be cultural sensitivity to all the issues.

Now I would like to let one of my co-sponsors go on.

**Dr Van Hoof:** I would like now to comment on the bill in more detail, and we'll take it section by section. Part I, clause 1(c)—and this is the only one I will quote, because it's of such importance—talks about, "to recognize the importance of a person's needs and preferences in all aspects of the management and delivery of community services."

Our comment is, this should be the first principle of

long-term care and should be placed at the top of the list, bumping the others down. This reinforces and emphasizes the significance of the consumer in the long-term care system. In most of the sections, when you start to talk about consumers, it's at the end of the list of things, it isn't at the beginning, so we would like the order to be changed so the consumer primacy takes preference.

In part II, subsection 2(4), on page 6 of the bill, given the added potential for neglect and abuse of vulnerable people as a result of remaining in the community, perhaps in isolation and dependent on care from families, councils recommend the addition of a number 11 stating, "Services to deal with abuse of vulnerable persons." I think this has been demonstrated in the news and reported by many people, that the vulnerability of persons with disabilities and the elderly are certainly a risky thing, so I think it's important we deal with that in the bill.

1640

Subsection 2(6) of part II: Council recommends the addition of a number 7, palliative care services, be made available as well, and I'd also like to add a number 8, if I could, which wasn't in there, but respite services I think must be made available, and not only for families taking care of persons with disabilities but for medically fragile children. Children don't seem to be mentioned in here, and that's been one of the disability council's prime focus in the last three years. Medically fragile children I think should have access to services as well.

Subsections 2(4) to (7), pages 6 and 7: There's no indication of whether this listing of services is descriptive or limiting, that is, only these services will be part of long-term care. If this is a definitive list of these services that the long-term care system will provide, then there will be serious problems in trying to ensure that the long-term care system remains current and responsive to the evolving needs of neighbourhood communities as new and other services cannot be provided.

Given the silence of Bill 173 on how fees for service will be determined, it is unclear whether the artificial division of services according to particular categories is for the purpose of determining a fee structure or prioritizing service needs. Either is unacceptable. I think the fees potentially have a very degrading effect on most persons with disabilities and the elderly. It's known widely that persons with disabilities are in the lowest socioeconomic group in the country, so to charge fees to care for them is unheard of, I think. Long-term care legislation must guarantee that the provision of any service that is necessary to help a person stay in their own neighbourhood in their own home is free.

Under the new integrated homemaking program guidelines, a person must be receiving personal support services in order to qualify for homemaking. This restriction must be eliminated. In order to promote independence and "to recognize the importance of a person's needs and preferences in all aspects of the management and delivery of community services," we have to provide the necessary services that will keep the individual out of an institution without tying them to another service.

I want to emphasize again that we must be explicit about fragile children's right to access services supplied

by the long-term care program. Flexible funding will allow support for the parents. Otherwise, these children would end up in the hospital, more likely than in an institution, because of the high care needs. They may end up in even intensive care for some of them because of the needs that they have. So fragile children have to be addressed.

The other thing is attendant services must be available, and we would like the care part taken out of attendant care and recognize them for what they are. These are services that are being provided to the person. They must have access to all the services within the long-term care when they are still receiving their attendant services.

I'd like to skip over to page 11 of our brief. In order to promote a wellness model of service delivery and relevance of services to the consumer, the following amendment should be made to subsection 20(1), that the agency provides or arranges a multidisciplinary team of professionals and peer consumers, where peer consumers represent at least 60% of the team, and the team shall assist the person to state their needs only if required.

Then in part VII, clauses 29(4)(b) and (c), a person should always have the ultimate right to have access to any and all personal records in their own plain language and alternative formats, as required. If it is determined that a record may be harmful to an individual, there should be a provision to warn the individual and to provide such counselling and support as may be necessary if he or she decides to view the records.

The council believes that a person's right to access his or her own personal records should be paramount and that this should be guaranteed in all sections of the bill that refer to personal records, sections 23, 29 and 30. The bill reads as if the care giver has a right to be gatekeeper over the personal records and not allow the person to see. That, I think, is wrong and invades the privacy of the person and it really has to be addressed.

The last thing that I'd like to speak about is on page 15, part XI, subsection 56(1). The advisory councils would like to be involved in any discussions concerning the regulations. We firmly believe that full community discussions are required in developing these.

Mary dealt with that very thoroughly. Bill, have you got something to add?

**Mr Hughes:** I think, coming from the two prior presentations, one of the things I see in here is that we're discussing the need for openness in the system, that it can't be a closed system just at the mercy of specialists and professionals, no matter how well intentioned that is. Just the mention of openness of personal records, it seems to me that is an essential quality that seems to be denied in this system.

We also want to see openness in the way in which business is conducted by district health councils and by the MSAs themselves. These organizations are doing very busy work in the community and I think the community has to be able to see what is going on. So not only shall we want to see the directors of these organizations represent the community and represent consumers, represent seniors, represent people who need support; we want to

see what they do being guided and being monitored by seniors in the community. It may become clear in the regulations but it isn't clear in the legislation that that's going to be the case.

The second thing that has been mentioned is that we have submitted three reports on our concerns before. In looking back over them, we find there are several items that we proposed, and I suppose this is inevitable, that weren't picked up in legislation. But it made us wonder to what extent there has been real listening in here, so that is why we're brave enough to kind of add in again some of the items we thought were important at the beginning that either have slipped through the chinks in the netting or it has been decided that they are not important enough.

One of the items would be support in questions of elder abuse. There's a lot of attention being paid to elder abuse these days. A lot of people are involved, the abuser and the victim, and there needs to be some practical way of supporting people who are caught up in this terrible situation.

A second thing that we don't think has been well enough explored in this long-term care has been palliative care, the support of people who are towards the end of their days, and the families and the people who are trying to support these people we will, one of these days, replace and become part of.

The third thing it seems to me that not enough attention is paid to is supportive housing. Surely, if people are going to be moved back into their community, then they need to have someplace to live in and it may not be appropriate to have their own home or to live with their in-laws or children or whatever. I think supportive housing is an issue that really hasn't been faced very well here.

My comments are really that there's still a lot of understanding that we are missing in this, and we hope the regulations will give us a chance to look afresh at some of these things. We certainly support the concept of long-term care, and seniors are very much looking forward to it. Thank you.

1650

**The Chair:** Thank you very much. Members of the committee, we have before us the three advisory councils and I am going to permit a question from each of the caucuses. In the normal rotation we would have begun here with the NDP, so what I'm going to do is to begin with Mr Malkowski. I ask members to be, in their usual fashion, short, sharp and succinct in their questions; that way I just think it takes advantage of having representatives from the three councils with us today.

**Mr Malkowski:** Thank you very much for your presentation. Some of your concerns are similar to the ones I have in terms of the guarantees of supports, when you're talking about access to information and the communication that is necessary to make it accessible and the need to be culturally sensitive when communicating. If the MSAs cannot do that, then I think we could call that communication abuse if there are not the supports that are necessary.

I'm asking the parliamentary assistant if an amendment could be considered to guarantee a level of support services for people who require access to information from the MSAs and to make sure that the DHCs can develop plans that identify ways to remove barriers so that the communication and the information can become more accessible, not only in their planning but also when they are thinking about barrier removal.

**Mr Wessenger:** I'm going to ask our policy person, Mr Quirt, to indicate how presently matters are communicated, how they intend to be continued and how this information should be made available.

**Mr Quirt:** We think that the bill doesn't pose a barrier to clients accessing their records in the long-term care system and we went to special lengths to ensure that a care giver or someone arbitrarily, an agency, couldn't withhold that kind of information from a client. If there's a problem with the way we've drafted it, perhaps you can let us know specifically, but we feel that we have achieved that objective of ensuring that clients do have access to their information and to the records.

I think Mr Malkowski's question also related to information generally, and I know Mr Hughes mentioned information from the district health council. My understanding is that the DHC meetings are public meetings, open meetings, and we can certainly inquire as to their process for the distribution of their minutes and so on at the planning committee level and at the DHC level and let you know how one would access the records of those meetings.

Off the top of my head, I'm not sure if they have a distribution list for their minutes or how that works, but I've been present as a guest at their meetings when there have been lots of people in the room listening and taking an interest.

**Mr Wessenger:** I'm just wondering if I might follow up Mr Malkowski's question to ask the group. In looking to this whole question of accessibility to information, I have somewhat of an interest in that myself, having conducted a large number of hearings with respect to the hospital sector, and certainly in the hospital sector there are now recommended protocols and procedures with respect to openness of information, for instance, open board meetings and so forth. Are you looking at a similar type of level of openness with respect to an MSA equivalent or are you looking for perhaps even a higher standard, to look at perhaps the municipal or school board models for the question of openness and access to information?

**Dr Van Hoof:** I really think what we want is open—we call it transparent. We'd like it to be as open as possible so that anyone can get the information they need and to know what is actually happening because for so long, for instance, the district health councils have been almost behind closed doors. I don't think they were closed meetings, but certainly no one was notified as to when they were available and when their meetings were being held etc. It wasn't something that was widely publicized and no one knew how the people got on—that's still a problem right now, getting people with disabilities and the elderly on district health councils.

**Mr Wessenger:** I certainly agree with your comments. We have to have a much higher sort of profile as well for these organizations. One of the problems, perhaps, at the moment with such a multiplicity of agencies and so forth is that you don't have the profile with respect to the community. Hopefully, with a higher profile with an MSA, we can develop a much more open and accessible system.

**Ms Szkambara:** Could I just add to that, if I may? With the district health councils, I find that the ethnocultural communities also are sometimes not included in many of the sessions or don't even know the information of what is going on. So we would really appreciate the fact that ethnocultural communities also be included and given information.

**Mrs O'Neill:** Thank you so much for coming. I think, Dr Van Hoof, that you presented on Bill 101 in London, if I remember, on a much stormier winter night. I remember that well.

I'm very pleased that you brought forward the statement that the language of this bill is not friendly to the consumer. I like your suggestions. I hope the government will take them to heart. Some of them really do not require a lot of change, maybe only a change of order. I'm pleased that you've reiterated your continuing concerns because they're very important: the elder abuse, the palliative care and the supportive housing. They're not yet in the bill, you're right, and I think the more we hear that, the more chance we have of getting something in the bill on that.

I'm going to ask the parliamentary assistant or the ministry officials if they can give you any comfort in your comments about children. That has come forward before. I'm just wondering if we can get a statement about how this bill affects children. Are they included? We know the school program is involved, but are children generally, particularly children with disabilities, included in this bill and how are they included?

**Mr Wessenger:** I am going to ask Mr Quirt to respond to that to indicate what areas are covered in this bill.

**Mr Quirt:** Clearly, children are very much a client group of the home care program currently, as you're aware, and certainly some of the needs of children and their families present the biggest challenge to the home care program across the province in meeting the needs presented and allowing for children to live at home as opposed to living in an institution.

So yes, very much so children continue to be clients of the multiservice agency in the same way that they're clients of the home care program now for visiting professional services, like nursing and physiotherapy and so on. As Ms O'Neill pointed out, we will continue to provide those services to children in a school setting as well.

I might add that the bill will also fund supportive housing. I know Mr Hughes is a proponent of that service model, and we are in the process of adding \$40 million to our funding base for supportive housing and this bill will fund approved agencies to deliver those support

services in designated apartment settings. It'll fund our existing ones and our new ones. It'll also fund palliative care in the general sense of funding the home care program and the MSAs, to deliver palliative care in the form of visiting nurses and homemakers and professionals, and through this act the \$4.8 million in new palliative care training initiatives will be funded as well.

**Mrs O'Neill:** Could I get a correction on the supportive housing? I'm sorry if I've had a misunderstanding. Is the supportive housing site then a centre attached to a local MSA or is that one of the satellites or how does that work?

**Mr Quirt:** No. Our preferred model for supportive housing is that we fund a support service agency to deliver a site-specific package of services in a designated apartment setting. That social service agency will continue to be funded separately, directly by the government, not funded through the MSA. The site itself is normally operated by another corporation that's in the rent-geared-to-income landlord business. In other words, we prefer to have the function of landlord delinked from the function of support service providers.

So the agencies now delivering supportive housing supports will be funded under this bill and a number of new ones will be funded under this bill due to the program expansion, but they won't be funded through the MSA.

**1700**

**Dr Van Hoof:** I just want to make a comment about respite care for children. Often it is available only if the family's in crisis, and that's not good enough, because what often will happen then is the children have to go into a hospital rather than a planned respite care or an emergency respite care, in the sense that if the basement flooded or you have a death in the family, the child ends up in hospital while the family copes with the other emergency. Instead of that, it would be much more cost-effective if you had a respite worker able to come in and look after the child and such and also better for the family and the child, if that was available.

**The Chair:** Thank you very much for coming before the committee this afternoon and for your joint presentation. We appreciate it.

**Ms Szkambara:** Thank you for the opportunity.

**Dr Van Hoof:** I hope the complete brief will be reviewed and considered.

**The Chair:** Yes, it will.

ALS SOCIETY OF ONTARIO

**The Chair:** Members of the committee, just so people understand how we're proceeding, we will now hear from Mr John Muirhead, who is with the ALS Society of Ontario, and then go to the College of Nurses and finish this afternoon with the Community Occupational Therapists and Associates.

Mr Muirhead, I welcome you to the committee. We're glad that after some transportation problems you have been able to join us.

**Mr John Muirhead:** Mr Chairman, ladies and gentlemen, first I apologize. In all the years that I've been

riding on Wheel-Trans, this is the first breakdown that I have been involved in. I apologize for being late.

**The Chair:** That's quite all right.

**Mr Muirhead:** Thank you also to the previous people, the Ontario advisory council, for filling in ahead of time for me.

Thank you for allowing me to talk a little bit about amyotrophic lateral sclerosis, which is known as ALS, and commonly called the Lou Gehrig disease. ALS is a progressive, irreversible disease of the nervous system in which the motor nerves wither and die. Since the movement messages do not reach the destination muscle, the muscles themselves do not become exercised and they in turn become wasted and atrophy. Persons with ALS become more and more disabled, unable to walk, unable to dress or feed themselves, unable to speak and eventually unable to breathe. ALS can strike anyone between the ages of 20 and 90, and the normal prognosis after diagnosis is death within four years.

At the present time the cause of ALS is not known, at the present time there is no known therapy or treatment which will slow, stop or reverse the effects of ALS and at the present time there is no known cure.

ALS is not contagious. While the body wastes away, the mind and mental thought processes are not affected. Thus, the person with ALS knows that he is dying but is powerless to do anything about it. While the voluntary muscles are affected, the involuntary muscles and organs, such as the heart, the bowels, the bladder and so on, are not affected. Similarly, the senses are not affected. Persons with ALS can feel heat, cold and pain.

As persons with ALS become more and more unable to look after themselves, the spouse or other family member becomes the primary care giver. Persons with ALS require more home nursing care than many other disabled people. Persons with ALS require moving on a regular basis to prevent painful cramping. They require suctioning of the throat and lungs quite frequently. Physiotherapy, moving of inoperable joints, must be done on a daily basis to prevent the joints becoming stiff and painful. Because of swallowing difficulties, dietetic services are required on an ongoing basis. Due to the loss of voice, persons with ALS require the services and assistance of a speech pathologist on a continuing basis. Care giving to a person with ALS is a 24-hour, seven-days-a-week, 52-weeks-a-year job.

It is a fact that persons with ALS would rather remain in the home environment than be admitted to hospital. While the home care and homemaker programs are helpful, they do not provide sufficient assistance to prevent the burnout of the family care giver. Care giver burnout requires hospitalization of the person with ALS and thus increased cost and burden on the health care system.

If the family cannot perform as the primary care giver, the only alternative is to place the person with ALS in an acute care hospital. Many hospitals, however, do not want to accept a person with ALS who has deteriorated to the ventilation stage, since this person requires intensive-care-unit nursing on a long-term basis.

The ALS Society of Ontario welcomes the proposed

introduction of universal long-term care and the multi-service agencies but urges the committee to recommend to the minister that more in-home assistance is required. Because a person with ALS becomes completely dependent on others, the society urges the committee to recommend to the minister that a diagnosis of amyotrophic lateral sclerosis be considered as a special case and restrictions on the amount of in-home care available to persons with ALS through the home care and other programs be dispensed with. We would recommend that a minimum in-home care of 16 hours per day, every day, be available to those persons with ALS who wish to remain in their home environment.

The society requests the committee to urge the minister to remove all restrictions on the provision of in-home professional services; that is, nursing, physiotherapy, occupational therapy, speech pathology and dietetic aid for persons with ALS. We would further urge the committee to recommend to the minister that all multiservice agencies must provide all services and that no exceptions, as outlined in section 15, be permitted.

Thank you for your attention.

**Mr Tilson:** Thank you, Mr Muirhead. I've met you several times in the past and it's good seeing you again. I can only tell members of the committee that I sympathize with individuals who have had this disease and what they've gone through, having experienced it personally with my father, who ultimately went into the latter stages of this disease.

I congratulate you on your presentation for, if anything, trying to help people pronounce the words, let alone tell them what the disease is.

I can tell you that having watched my father go through the various stages, all of the things that you're saying, I hope the committee does look at it with respect to this specific disease. If he hadn't had the assistance at his home before he went into a hospital, if he hadn't had the physical therapy care and the speech and language pathology services and the other homemaking services, life would have been unbearable. So I hope the members of the committee will listen to Mr Muirhead's words.

I have one question for you and that is, I would like you to comment on the impact of the multiservice agencies on volunteer groups, which includes different groups that support the ALS. It has been said by a number of groups, particularly the Red Cross and the Kidney Foundation of Canada, that people simply won't volunteer for government agencies, for faceless government bureaucracies.

1710

I know in my community of Orangeville there is a support group made up of volunteers to assist members of families whose relatives have this disease in how to deal with it. I know that there is a separate organization to educate members of the public in my community and to raise funds. I know that there is a service club, the Optimist club, of which I happen to be a member in Orangeville, that participates in the Cornflower Day to raise funds and that also participates in the baseball fund-raising program. I also know the people who are in these

groups, and I know their reaction. It's one thing to volunteer for a group such as ALS, with the emotion and the passion and all of that, but it is quite something else to volunteer for a faceless bureaucratic service.

My question to you is whether the ALS society joins with other groups such as the Red Cross in the fear of the impact on volunteerism, particularly with respect to ALS.

**Mr Muirhead:** I think that's a very apt comment. We have discussed the problems with the MSAs and allowing volunteers to continue to work for the ALS society. We do not feel that the MSA will wipe out the volunteerism of the charities. We feel that there will still be enough things for the society to do, to look after the support, to provide information, to provide assistance in any way that we can. So while it may be so that people don't want to volunteer for a government agency, we feel that they will continue to volunteer for organizations such as the ALS society.

**Mr Tilson:** Thank you very much. I hope you continue with your mission telling the people of Ontario all about ALS, because we need to know more about it.

**The Chair:** Mr Muirhead, that has been most helpful and I think, as Mr Tilson says, this is something that we don't know as much about as we might think.

**Mr Muirhead:** I'll be glad to come back and educate anybody any time.

**The Chair:** Okay, I'll keep that in mind. Thank you again.

#### COLLEGE OF NURSES OF ONTARIO

**The Chair:** I call on the representatives from the College of Nurses of Ontario please. I want to welcome you, in turn, to the committee.

**Ms Anne Coglan:** I'm Anne Coglan, the president of the College of Nurses of Ontario, and with me is Margaret Risk, the executive director of the college.

The College of Nurses of Ontario is a statutory body which regulates approximately 110,000 registered nurses and 35,000 registered practical nurses registered in the province. Our mission is to regulate nursing to protect the public interest. We appreciate the opportunity to present our comments on Bill 173, An Act respecting Long-Term Care, to the standing committee on social development.

The College of Nurses' measure for assessing this bill is the extent to which it protects the public right and interest in having safe, ethical and accessible care and services. In this regard, the college supports the purposes of the bill as set out in section 1. We are concerned, however, that the bill as currently drafted contains some significant omissions and flaws that need to be addressed if individuals in need of long-term care and services are to receive safe, effective and ethical care.

We have two broad areas of concern:

First, making sure that client safety is sufficiently protected and that the system's ability to provide quality care is strengthened.

Second, making sure that the long-term care system is steered by consumer choice and need, particularly consumer rights of self-determination.

We also note a number of issues which we believe

may hinder effective implementation of the act.

With respect to our first area of concern, the College of Nurses is encouraged by the intent reflected in the bill to recognize the need for quality care. We firmly support those elements of the bill which we believe are in keeping with the principles of safe, effective and ethical care. It is our view, however, that several specific aspects of Bill 173 undermine these principles. These include:

—The failure of the bill to explicitly identify client safety as the first priority.

—The safety of clients placed on waiting lists.

—The rules regarding the purchase of services by multiservice agencies.

—The deferral to discretionary regulations of most of the substantive provisions relating to safe, quality care; for example, client assessment.

The College of Nurses recognizes that the fundamental intent of Bill 173 is to implement the government's long-term care redirection. This is clear from section 1 of the proposed bill, which opens with the commitment to ensure that a wide range of community services is available. The College of Nurses supports this purpose. But there is no analogous commitment to safe, quality care; only that the health and wellbeing of persons requiring services will be promoted.

We submit that the difference between "ensure" and "promote" is not semantic. It appears to be a careful choice of words which communicates an obligation in the first case but only an encouragement in the second case. This seems to be a case of misplaced priorities, which steers the overall thrust of the bill and which is likely to steer the development of the regulations if not corrected. In other words, ensuring a wide range of community services is not beneficial if there is not a similar commitment that these services are safe and effective. The college submits that the bill needs to be strengthened in terms of its commitment to safety and quality of care.

This failure to give appropriate priority to client safety is reflected in subsection 21(2) of the bill, which specifies that if a community service outlined in the client's service plan is not readily available, the client is placed on a waiting list until the service becomes available. Aside from the issue of how or if a holistic assessment of client needs is to be undertaken by the multiservice agency before a referral to an individual service agency occurs, there is no reference to what is to be done to address the needs of these clients during this waiting period, an omission which undermines the importance of the continuum of care and may jeopardize the safety of the client. Every effort must be made to monitor waiting lists to ensure that services are provided in a timely manner.

The proposed service purchase rules outlined in subsection 13(2) are another illustration of the outcome of giving priority to range of service over safety and quality. The bill provides that multiservice agencies cannot spend more than 20% of their budget for the purchase of each of the four elements of community services from independent service providers: community support, home-making, personal support and professional services.

We understand that the purpose of this provision is to ensure that the multiservice agencies provide the full range of community services. While the College of Nurses supports this goal, stipulated budget allocations fail to acknowledge that the needs of a particular community or group of individuals may not fit neatly into this formula. The flexibility that is provided in the bill with respect to the minister's power to exempt a multiservice agency from this formula relates solely to phased-in implementation of the bill and bears no relationship to any assessment of community needs.

The multiservice agency is a new, untested service delivery system. Greater flexibility is necessary. The College of Nurses believes that if client safety is the priority, this provision should be amended to allow agencies to allocate their budgets for the purchase of any combination of the four groups of services, based on the assessment of local client and community needs.

The College of Nurses appreciates that the approach of the bill is to defer the development of critical safety and quality of care factors such as client assessment, service plan development and revision, and care provider preparation/qualification to the development of the regulations. We believe, however, that these factors are essential to ensuring that safe, quality care is provided and that the relegation of such issues to discretionary regulation-making authority is not sufficient.

#### 1720

In this regard, the College of Nurses submits that the following principles be incorporated into the act itself rather than left to the regulations: the need for knowledgeable assessment, both initial and ongoing, of the client's service needs; the need for competent and accountable providers of professional services and the articulation of accountability mechanisms for providers who are not regulated; and the need for continuous monitoring of the level of acuity of each client and the associated level of service and care giver requirements.

One means of accomplishing this is to go further than providing a regulation-making authority and require regulations to address these factors. Furthermore, it is the regulations which give the real assurances of safe, quality care. We strongly believe that developing these regulations in partnership with providers and other key stakeholders, therefore, is necessary. We request a formal commitment from the government that regulation development will not occur without full and open consultation with the stakeholders. In particular, we underscore the extensive experience of the College of Nurses in the area of quality care. We will be pleased to participate in this important process.

With respect to our second area of concern, the College of Nurses strongly supports the concept of a client bill of rights as proposed in Bill 173. We believe that such a bill of rights should reflect the client's right to participate in decisions regarding the provision of services and to receive information about every aspect of the service to be provided. This includes having information about the level of education or preparation of the person or persons who will be providing the service.

Paragraph 3(1)4 specifies only that the client has the

right to "information about the community services provided to him or her and to be told who will be providing the community services." The message conveyed here does not clearly articulate the client's right to participate in these decisions. This provision does not fully support the principles of consumer empowerment and self-determination. The fact that partnerships between clients and providers enhance the system's effectiveness must be recognized. Involving the client in the development and implementation of service plans maximizes the integration of the kinds of services needed and wanted by the client and client satisfaction.

As we noted at the outset, the College of Nurses' primary concern with respect to Bill 173 turns on the extent to which the bill provides sufficient safeguards to ensure safe, quality care and the protection of consumer choice. As well, however, we have identified a number of provisions in the bill which fail to address some of the practical problems involved in successfully meeting pivotal objectives such as ensuring service accessibility, availability or effective planning.

Subsection 11(1) specifies that multiservice agencies will be authorized to serve within the boundaries of specific geographic areas. The client population of that area will have access only to those services provided by the local multiservice agency. By placing geographical barriers to access, this service delivery approach ignores, to a considerable extent, the possibility that the services needed by certain clients, and in particular by marginalized populations, may not be available at the local multiservice agency. The needs of clients are defined by a range of dimensions, one being culture. It would be more constructive to facilitate client access to needed services from neighbouring multiservice agencies when not available at the local level.

Subsection 12(1) lists the mandatory services to be provided by each multiservice agency. At the same time, district health councils are given authority to identify community-specific service needs. The extent to which a system characterized by scarce resources can adequately fund the range of mandatory services proposed is not clear. Whether each community will have sufficient funding to provide additional services tailored to meet the specific needs of the individual community seems doubtful. Adequate funding is obviously key to the successful implementation of this proposal.

The College of Nurses supports the government's commitment to consumer membership on district health councils. The value added contributions that can be made by experienced service providers, however, must not be overlooked. We urge government to recognize this factor and provide for the inclusion of representatives from the nursing and other health and social service professions in the membership of the councils.

In summary, the College of Nurses of Ontario recommends:

—That Bill 173 be strengthened in terms of its commitment to safety and quality of care;

—That every effort be made to ensure that waiting lists are monitored to ensure that services are provided in a timely manner; for example, exceptions to the rules

limiting services to a specified geographic area be allowed where client safety is concerned;

—That multiservice agencies be allowed to allocate their budgets for the purchase of any combination of community support, homemaking, personal support or professional services, based on the assessment of local client and community needs.

—That the bill require the development of regulations to govern the quality of services and that the regulations address the need for: knowledgeable assessment, both initial and ongoing, of the client's service needs; competent and accountable providers of professional services, and the articulation of accountability mechanisms for such providers who are not regulated; continuous monitoring of the level of acuity of each client and associated level of service and care giver requirements.

—That the regulations be developed in partnership with care providers and other key stakeholders.

—That the client bill of rights clearly articulate that the client has a right to participate in decisions regarding the provision of services and to receive information about every aspect of the service to be provided, including the education or preparation of the person or persons who will be providing the service.

—That the multiservice agency model provide unrestricted access to services.

—Finally, that service providers be included in the membership of district health councils.

In closing, we again note that the college of nurses has extensive experience in the area of establishing standards relating to the safety and quality of care and that we would be pleased to provide whatever assistance we can in implementing these recommendations.

**Ms Carter:** Thank you for a thoughtful presentation. I certainly appreciate your concern with the consumer, or the client, which is what hopefully this is all about, that we shall give the best possible service. I hope and believe that some of the questions you've raised are already catered to, that we can bring to your attention the fact that you don't need to have those particular fears. One is, for example, I believe there will be care providers on the board. It's a stipulation that there should be one third at least consumers, maybe more, and some care providers.

You express a concern that because of the geographical boundaries of the agencies, services can't be accessed beyond those limits. I believe that is not the case. For example, if you had somebody with an ethnic background or religious background who needed care that gave them that background, that could be accessed. I think one of the big pluses of the system we're bringing in is that by having this single point of access to somebody who has all the information and can call on all the expertise necessary to find out what that person needs, they will in fact be able to access a suitable care provision that perhaps is outside their local boundary and that they never would have known about in other circumstances.

Perhaps we could have some details on that point.

**Mr Wessinger:** With respect to this whole question, I noticed your comments about geographic barriers. Let me assure you that certainly it's not the intention in the

act to create geographic barriers. You'll note one of the exemptions to purchase of services in the act is purchase by one MSA from another MSA of services. There's no limit on, say, in the Metro Toronto area, one MSA purchasing from another MSA, or even Durham purchasing from Metro Toronto. The idea is to allow that, shall we say, specialization to occur in individual MSAs where that's appropriate.

As we all know, the MSA model is going to be developed by the district health council. I would anticipate that the models that are recommended by the local district health councils, for instance in Metro, will allow the necessary cultural sensitivity and the specialization developed that's necessary to have the system be comprehensive. I'm sure that's going to involve purchase of services by one MSA from another, and that is permitted under the act.

1730

While I have the opportunity, I might as well just comment on some of your other points. You indicate the importance of involving the client in the development and implementation of service plans. I can assure you that is in the act. It's section 23. It says that the clients shall participate, I believe, fully in the development of the service plan. On your other concern about timeliness, I couldn't agree with you more. Again, I believe it's in the act that once the service plan is developed, there's an actual legal obligation to provide the service in a timely manner. So there's an actual legal obligation to provide the service once the service plan is developed.

I don't know whether there are any other items I should deal with. I believe that pretty well covers the question of waiting lists, participation of the consumer and the purchase of services out-supplied from other multiservice agencies.

**Ms Coglan:** I would just clarify that our concern about the waiting period was up front, in the initial assessment time. That was something we wanted to point out, that there didn't seem to be a specified period between the request for assistance, assessment, and then provision of service.

**Mr Wessinger:** Your concern basically, then, is not in the waiting list once a person has a service plan developed, but the concern that people might not have access to developing a service plan in a timely manner?

**Ms Coglan:** That's right.

**Ms Carter:** Of course, it would depend on the circumstances. If somebody wants access to Meals on Wheels, hopefully that can happen the next day, whereas if their needs are more complex, it takes some time to fully develop the structure that the person requires, although some things maybe need to be done quickly.

But you did also raise the question of the 20% purchase and so on. We did have a group here earlier today that was talking about seamlessness, how we want to minimize the divisions between the different aspects of care because, after all, these are subtle things and different people need different combinations and gradations.

It's my feeling that by having an integrated multi-service agency rather than accessing outside agencies for

specific services and paying, that we are going to develop something that is more flexible, integrated and more able to adapt to the needs of particular clients. I'm just wondering what your feelings on that might be.

**Ms Cogan:** We certainly couldn't agree with you more. Our concern was that the 20% stipulation may be a barrier to that provision of seamless service and providing services truly based on individual and community need.

**The Chair:** Thank you.

**Ms Carter:** Time up?

**The Chair:** I'm sorry, we have one more presenter and it is getting late. I regret I'm going to have to bring this part to a close, but I want to thank the college for coming before us today.

#### COMMUNITY OCCUPATIONAL THERAPISTS AND ASSOCIATES

**The Chair:** I call on the representatives from the Community Occupational Therapists and Associates. I want to welcome you both to the committee.

**Ms Mary Horan:** My name is Mary Horan and I'm the chair of the board of directors of Community Occupational Therapists and Associates, commonly known in Toronto as COTA. With me is Barbara Quinn, the executive director of the agency. We are very pleased to be given the opportunity to present our views on Bill 173, An Act respecting Long-Term Care.

For those of you who are not familiar with COTA, I'd like to begin by telling you about the organization. We're a not-for-profit Ontario corporation that provides a range of occupational therapy and other rehabilitation services to people in their homes and community in Metro Toronto. We were founded in 1973 in response to the need for home-visiting occupational therapy services. We strive to promote health and function, to prevent dysfunction, to attain goals of independence, and to improve, develop and maintain the quality of life for persons with functional deficits.

We serve people of all ages with functional challenges resulting from a variety of disabilities. Twenty-one years ago, clients numbered 100. Today we have over 7,700 consumers served through a range of programs annually. At any one time, there is in excess of 1,500 seniors, adults with disabilities and people of any age who require health services at home or in school.

We deliver community-based occupational therapy services to clients through a home care program and a series of grant-funded programs. Clients in the home care program receive assessment, rehabilitation, education and consultation services. Examples of our grant-funded programs are listed in the text. These services are provided by over 200 staff and associates, and complemented by more than 500 volunteers.

We have an ongoing interest in long-term redirection, as half of our clients receive services through the home care program. We have actively participated in Ministry of Health and district health council focus groups and consultations, and we are taking part in implementation planning for multiservice agencies in Metro Toronto. Our participation reflects a strong interest and commitment by

staff, associates and volunteers to make reform work in practical ways to benefit our clients.

Our response to Bill 173: While we are in strong support of long-term care redirection, we have a number of concerns regarding the proposed legislation. In the remainder of the presentation we will focus on these issues.

First of all, quality of care: The proposed legislation designates occupational therapy as a core professional service. However, the act does not specify what type of worker may provide certain services. According to the compendium on page 18, "This will permit alternative, lower-cost workers to provide services, if the task or procedure is not restricted to a specific scope of practice under the Regulated Health Professions Act."

We believe that professional intervention may be viewed as an expensive option versus a cost-effective approach in the long run. As a result, MSAs may use lower-cost staff for all services except those requiring professionals as stipulated in the Regulated Health Professions Act.

We recognize a role for paraprofessionals in the delivery of community services. We have experience with this at COTA. For example, we use community resource workers to supplement the work of occupational therapists. The therapist provides assessment and ongoing case supervision, while the community resource worker provides skills teaching, linking and monitoring services. We are concerned, however, that lower-cost workers may be used to replace professional service providers in MSAs. We do not believe the use of paraprofessionals in this manner necessarily indicates long-term savings or most appropriate care.

In addition, we expect 15 to 20 MSAs to be established in Metro Toronto. How will quality of care and standards of practice be assured through the decentralization structure being proposed? Moreover, how will clinical support, professional development, evaluation research, and education and training be maintained? We urge the government to establish a regional body in Metro Toronto which will provide these essential supports and ensure consistent standards of care.

Secondly, entitlement: One of the goals of long-term care redirection is to improve consumers' access to community services. In our opinion, access implies more than entry to the system; it also signifies the type and range of services available.

Bill 173 places restrictions that may actually limit consumers' access to in-home services. The proposed legislation allows the Minister of Health to provincially mandate services. Once these services are provincially mandated, will they be universally guaranteed? On what basis and by whom will rationing decisions be made once this entitlement is removed?

Thirdly, voluntarism: Like other organizations, we are concerned that volunteer retention and support may disappear in the transition to the new MSA system. Volunteers are one of the most valuable components of the present community sector. At COTA, for example, volunteers contribute to extending the organization's

services beyond the limits of clinical intervention. Therefore, we suggest that the Ministry of Health provide adequate funding and support to recruit, train and retain volunteers.

Fourthly, linkages between all sectors of Ontario's health care system: Many sectors of Ontario's health care system—for example, acute care, chronic care and mental health—are currently undergoing reform initiatives. We encourage the government to facilitate planning as well as service delivery linkages between these sectors. Otherwise, clients who require services from more than one sector, such as psychogeriatric consumers, may find themselves without care.

1740

**Ms Barbara Quinn:** The organization of services: Decentralization of services implies increased administrative costs for urban centres, particularly Metropolitan Toronto. We reason that cost savings are possible if some administrative functions are centralized. We also believe it will improve coordination of community services across Metro. Examples of this would include things like information systems, payroll and purchasing, education and training, and the delivery of specialized services.

Transitional planning: We recognize the complexity of designing and founding MSAs throughout the province. However, in Metro it means the amalgamation of some 250 community agencies. Consequently, the costs of establishing this MSA infrastructure could be high. Startup costs would include the transitional funds for labour adjustment, retraining, administration, severance, increased unionization, pay equity, and legal and consulting fees.

We recommend that the Ministry of Health issue a statement concerning transitional planning and the costs involved. Organizations such as ours, which continue to provide these services during the transitional phase, need to know what we are facing.

Specialty services: At present there is a constantly increasing demand for rehabilitation services. In addition, there is a shortage of trained rehabilitation service providers. This is evident in waiting lists for rehabilitation programs within Metro as well as throughout the province. At COTA, for example, approximately 500 people are now waiting for services. Accordingly, we are concerned that every MSA will not have the human resources necessary to respond to clients' complex and specialty needs.

We recognize the benefits of providing a range of services at the local level, and support it. However, we also recommend that specialty services be provided on a regional basis. We encourage government to consider alternate models for the provision of these specialty services.

We request a change to subsection 13(2) of the act, which limits purchase of services to 20% of the MSA's approved budget. We believe this change is necessary to enable MSAs to respond to clients' changing demographic, clinical and functional needs, as well as to preserve some consumer choice.

Mental health services: Many consumers with severe

mental health problems are currently receiving community services through the home care program for Metropolitan Toronto. At any one point in time, we are servicing 1,000 mental health clients through the home care program. We are concerned that funding for these services could be lost during the transition to MSAs, and as a result these clients could be without care. Therefore, we strongly advocate that the Ministry of Health ensure these services take place, as well as preserve the continuity of care through linkages between the long-term care system and the mental health system.

Children and school support services: School support services for children were not identified as community services in the act. At present, we provide in-home and school support services for children through the home care program. Consequently, we advocate that Bill 173 be amended to include a section protecting in-home and school support services for children.

**Ms Horan:** In general, then, we are concerned with the prescriptive nature of the act. The Minister of Health has been given extensive discretionary authority over in-home services through regulations to be developed at a future date. This seems to indicate the potential for community services to become directed and controlled. We believe that a great deal of regulation may hinder service delivery in the community sector, where flexibility and responsiveness have historically been key to its success.

We recognize the need for professional standards in regulations throughout the province. However, as Ontario consists of diverse communities, policies for urban centres like Metro Toronto may not be relevant in other areas of the province. Communities require the ability to create agencies that will be sensitive to the needs of their neighbourhood. Therefore, we recommend stakeholders be actively involved in the process of developing regulations.

In conclusion, we believe Bill 173 does much to advance access and coordination of community services for the elderly and disabled. You have heard our concerns. We request the government to consider the following recommendations before the act is implemented and regulations are developed:

- Establish a regional body for Metro Toronto which will ensure consistent standards of care, as well as provide education, training and clinical support to local MSAs.

- Guarantee community services which are presently insured.

- Provide adequate funding and support to recruit, train and retain volunteers.

- Facilitate planning, as well as service delivery, and linkages between all sectors of Ontario's health care system.

- Issue a statement concerning transition planning and the costs involved.

- Amend subsection 13(2) of the act to eliminate the 20% limit on purchase of services.

- Ensure in-home mental health services, which are now provided through the home care program.

—Protect in-home and school support services for children.

We urge government for full participation and consultation with stakeholders in the development of regulations and in all stages of implementation planning.

**Mrs O'Neill:** I want to thank you a lot. Actually, it's really quite uplifting to know that of the last three presenters, two have mentioned children. I'm very pleased you are one of those. I think you have justifiable fears when children are not specifically mentioned in this bill. I think you have justifiable fears regarding mental health not being included in this bill. We've had quite extensive discussions in other locations; I think it was in Hamilton that we discussed this quite openly, and what we have found—and I may be corrected if there is a correction—is that they will be an option for the MSA to pick up. That, to me, is very fragile.

I understand, however, that there are joint talks now going on with a couple of branches of government that have jurisdictional mandates in these particular areas of service, and I hope those talks are fruitful, because I really do think mental health cannot be divorced from this long-term care reform or from the MSA, nor can it be left to chance.

You have said something in your brief that I would like to perhaps have you explain a little further and then certainly have the parliamentary assistant or the ministry officials speak to. It's at the bottom of page 3 and the top of page 4. I think it's a very good question. You really are asking, what happens if services are just not there? Who is going to make the decision? Is it the placement coordinator? Is it the governance structure of the MSA? Is it the actual provider? Who is going to make that ultimate decision of whether the service is available, whether the person goes on a waiting list, whether they get one hour a week or half an hour a week?

I think that's a very good question that hasn't been asked very often in this set of hearings. Although the bill seems to be full of rights, seems to be full of access to services, we know that waiting lists are part of the bill as well. So could you tell us, Mr Wessinger, what your reaction to these statements of mine and the statements of the occupational therapists would be?

**The Chair:** I'll ask the parliamentary assistant to comment on those. He also wanted to just clarify a few points, and then, if you have any questions or comments on his comments to Ms O'Neill's comments, who had responded to your comments, then, as befuddled as we may be at this late hour, we will bring it to an end.

**Mr Wessinger:** I will make some comments, and as usual I'll ask Mr Quirt to supplement them because he usually can add some items. But first of all, generally with respect to the whole question of provision of services, basically the same services that are now provided will continue to be provided, and that includes your reference with respect to mental health services now provided through the home care program. There's no change there. The same on the second item with respect to in-home and school support services for children; there will be no change. They will continue to be provided under the MSA.

It should be indicated that there's no target group mentioned in the legislation. There are no age barriers with respect to the provision of services. I think that should be made very clear.

In one of your comments, when you said, "community services which are presently insured," I guess it depends what you mean by community services, but certainly community services as I would define them are not an insured service. I'll ask Mr Quirt, I think, to see if there's anything else he thinks he could add to my comments.

**1750**

**Mr Quirt:** Just to follow up on Mr Wessinger's comments about ensuring that in-home mental health services which are now provided through the home care program will continue, we clearly intend to do that, and the programs and services we deliver through home care we described as generic services. In other words, it doesn't matter why you need the long-term care services, whether it's because you have a mental health problem or cancer or diabetes or whatever, we'll send the therapist and the nurses and the homemakers that you require. So that will continue. There is certainly no intention to exclude people who have a psychiatric problem, but of course the home care program is not going to be hiring a bunch of psychiatrists and dealing with the specialized mental health needs of those people. Clearly we are involved in discussing how our long-term care generic supports will complement a reform of mental health that's aimed at shifting some resources from institutional-based services to community-based services.

The same applies to the school program. We are going to do just as much through MSAs for children in school as we do now through the home care program.

On the issue of insured services, there have been two definitions that have been at work, I think, before the committee. One definition of insured service has been whether in fact there will be a charge for the service. I know that's how it's been interpreted some places.

It's our intention not to charge for things like personal care, nursing, therapists, the services of the home maker if somebody requires personal care. But it is our intention to continue to charge for those things that have charges now, things like the charge that's paid by an elderly person when a meal is delivered, three or four dollars for the meal, or the four or five dollars that changes hands between a volunteer driver and a consumer who's been driven to the doctor as a compensation for the volunteer's gas or something like that. There will continue to be charges like that, but there won't be any new charges for health care services like personal care services or nurses or whatever.

The other definition that's been at work is whether in fact the programs are funded under the Ontario Health Insurance Act, and it's been confused, if you like, with the adequacy of funding, because as you're aware, even though things like nursing visits and other professional visits have been in effect funded under the Ontario health insurance plan, home care programs have been attempting to manage their budget through the year with respect to costs for those programs. While the costs of those programs have gone up, the home care programs have not

willy-nilly been providing service; they've been making an attempt to match their resources with the clients' needs as they come forward. We have a 60-hour limit on homemaking services, for example. The average client gets I think about 27 hours. So there's an example of how home care programs have attempted to ensure that a wider range of people benefit from the programs and services provided.

If being an insured service was a guarantee of getting more money, then our colleagues in the long-term care facility side of the long-term care reform would disagree strongly, in that the programs that used to be insured, nursing homes, got significantly less money than the programs that weren't.

Those comments are in support of Mr Wessenger's.

**The Chair:** Any comment?

**Mrs O'Neill:** I'm still having trouble. I don't think the question on page 4 has been answered. On what basis and by whom will rationing decisions be made?

**Mr Tilson:** Good for you.

**Mr Quirt:** I'm sorry if I didn't make that as explicit as I should have. The decisions now as to how much service someone gets when they become eligible for home care, how many nursing visits they get or how many homemaking hours they get, are made by the staff of the home care program. Those decisions would be made by the staff of the multiservice agency, and now and in the future those decisions would be made within the context of eligibility criteria and provincial policy that are in place now and are being refined so that there's more flexibility in how they're applied.

**The Chair:** Did you have any questions or comments on what has been said?

**Ms Quinn:** With respect to the rationing issue, I think what concerns us primarily is in the event of some economic shortfalls, which we know we have ongoing difficulty with, how are we in fact going to redistribute these vital services, especially with respect to the health needs? We are seeing increasingly more severely ill, complex care cases in the community. That could well absorb tre-

mendous resources, increasingly with hospital closures and restructuring. How will those decisions be made, and will many of the elderly, who need community supports, in fact be lacking needed services because the high-end clients are going to drain some of this off? Who and how are all these decision going to be made?

**Mr Wessenger:** I might just comment on that. We now live in the reality of a managed health care system. We have for some time, and we've had to live within certain funding limitations. I think the MSA, though, is going to provide—first of all, there is a commitment to provide more money in the long-term care area. In the past the government has provided substantial increases in the area of long-term care, but I think it's suggested with the new MSA model, in a funding envelope for that model there will be more flexibility with respect to the MSA with respect to delivering services to each local community, so it'll provide more flexibility in how these funds are delivered in respect of the needs of that community.

But there will be, obviously, guidelines with respect to priorities, and obviously you'll have to give priorities to the persons who have the greatest need for the services, and the timeliness of service will have to relate again to the priority needs. A system does not work well unless it prioritizes. We have to prioritize, and that will be the job of the MSAs, as it is now the job of, shall we say, the home care case workers. Those same people will be working for the MSA and making many of the same decisions, hopefully with more flexible guidelines.

**The Chair:** And in terms of prioritizing, the Chair is going to have to prioritize. The committee's in need of its own version of long-term care. I want to thank you both very much for coming before the committee.

Committee members, we will stand adjourned until October 3. We will be meeting on October 3 and 4, beginning at 9 o'clock, and the schedule for those two days should be out next week. With that, the committee stands adjourned until 9 am on Monday, October 3.

*The committee adjourned at 1758.*





## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

\***Chair / Président:** Beer, Charles (York-Mackenzie L)

**Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

\*Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

\*Owens, Stephen (Scarborough Centre ND)

\*Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Malkowski, Gary (York East/-Est ND) for Mr Hope

Phillips, Gerry (Scarborough-Agincourt L) for Mr Eddy

Ruprecht, Tony (Parkdale L) for Mr McGuinty

Tilson, David (Dufferin-Peel PC) for Mrs Cunningham

Wessinger, Paul (Simcoe Centre ND) for Mr Martin and Mr O'Connor

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Wessinger, Paul, parliamentary assistant to the minister

Quirt, Geoff, acting executive director, long-term care division

Czucar, Gail, legal counsel

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Boucher, Joanne, research officer, Legislative Research Service

# CONTENTS

Thursday 15 September 1994

<b>Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,</b>	
projet de loi 173, <i>M<sup>me</sup> Grier</i> .....	S-2201
WoodGreen Community Centre of Toronto .....	S-2201
Brian Smith, president	
Amy Go, director, senior services	
Margaret Bryce, board member and member, seniors' advisory committee	
Villa Charities .....	S-2204
Dr Marisa Zorzitto, president, Villa Columbo Homes for the Aged	
Pal Di Iulio, executive director, Italian Canadian Benevolent Corp	
Older Adult Centres' Association of Ontario .....	S-2206
Anita Machin, vice-president	
William Krever, chair, business partnerships committee	
Ontario Home Care Programs Association .....	S-2210
Ruth Stewart, president	
Vida Mazza, executive director	
Freeport Hospital .....	S-2214
Pat Henderson, executive director	
Haldimand-Norfolk Transitional Steering Committee .....	S-2217
Ron Armstrong, consumer	
Margaret Toni, executive director, Community Homecare and Rehabilitation Services	
Mary Anne Baker, director, home care program	
Eddie Knakowski .....	S-2219
Older Women's Network .....	S-2221
Ethel Meade, co-chair	
Moira Bacon, member of council	
Senior Citizens' Consumer Alliance for Long-Term Care Reform .....	S-2224
Jane Leitch, chairperson	
Allan Burnside, member	
Federation of Provincial Non-Profit Organizations Working with Seniors in Ontario .....	S-2228
Dr R. Gordon Romans, president	
Marlene Muldoon .....	S-2230
Rosalys Lawrason .....	S-2232
Advocacy Centre for the Elderly .....	S-2233
George Monticone, representative	
United Way of Peel Region .....	S-2235
Rav Grover, president, board of directors	
Sally Pincock, agency staff	
Ontario Community Support Association, Area 7, Metropolitan Toronto .....	S-2239
Bau St-Cyr, chair	
Jean Green, representative	
Jerry Berman, vice-chair	
Linda Luste, representative	
Catherine Brookman, representative	
Ontario Advisory Council on Multiculturalism and Citizenship; Ontario Advisory Council for Disability Issues; Ontario Advisory Council on Senior Citizens .....	S-2243
Mary Szkambara, vice-president, Ontario Advisory Council on Multiculturalism and Citizenship	
Dr Shirley Van Hoof, chairman, Ontario Advisory Council for Disability Issues	
Bill Hughes, chairman, Ontario Advisory Council on Senior Citizens	
ALS Society of Ontario .....	S-2246
John Muirhead, past president	
College of Nurses of Ontario .....	S-2248
Anne Coglan, president	
Community Occupational Therapists And Associates .....	S-2251
Mary Horan, chair, board of directors	
Barbara Quinn, executive director	



S-70

S-70

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 3 October 1994

# Journal des débats (Hansard)

Lundi 3 octobre 1994

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

Long-Term Care Act, 1994

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



*50th anniversary*

**1944–1994**

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 3 October 1994

Lundi 3 octobre 1994

*The committee met at 0906 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Chair (Mr Charles Beer):** Good morning. The standing committee on social development is in session. We are again meeting to consider Bill 173. We have two very full days of presentations.

ROYAL CANADIAN LEGION, ONTARIO COMMAND

**The Chair:** I would like to call on Mr Jack Currie, chairman of the veterans' services committee, Royal Canadian Legion. Mr Currie, welcome to the committee. I know you're not a stranger to this committee. We're pleased to see you again. We have a copy of your submission.

Perhaps, just before beginning, I could remind committee members again that given the number of presenters we've tried to include, we will also today be continuing with the system of having one question per caucus, just so that we make sure we hear from everybody and are able to finish by 6 o'clock.

**Mr Jack Currie:** You've already heard presentations from other members of our veterans' services committee in Ontario Command, who presented a brief to you in Kingston. My brief today will be considerably shorter, and I merely wish to add to the concerns expressed by the District G representatives.

The legion, as you now are aware, has a strong commitment to the veterans and their dependants to ensure that they receive all the benefits to which they are entitled. We are concerned that in times of economic restraint all levels of government are attempting to downsize and reduce existing programs. Our veterans are aging and their needs are increasing as they age and their health declines. We have only a few years left to compensate those men and women who served in wartime and we feel a strong obligation to prevent erosion of the existing veterans' benefits.

The responsibility for veterans rests primarily with the federal government. However, provincial governments enact legislation which may impinge upon the existing benefits available to our veterans. Increasingly, it would seem, there is a need for dialogue between the federal and provincial governments to ensure that the hard-won benefits of veterans are not lost.

As our representatives from District G noted in their brief to your committee, we are concerned that there is

no mention of veterans in Bill 173. The veterans' health care regulations provide for the rights of certain eligible veterans to be admitted to the Veterans Affairs contract beds in Parkwood Hospital, Sunnybrook hospital and the Rideau Veterans Home/Perley Hospital. In the past, admission eligibility has been determined by Veterans Affairs on the basis of a veteran's service and the level of care required. With the advent of the placement coordination service, we are concerned that the veterans who meet this criteria may, at the discretion of the placement coordinator, not be admitted to the contract bed. We believe that legislation enacted by Ontario should provide special mention of the rights of veterans under the veterans' health care regulations.

The thrust of long-term care reform is to reduce dependency upon institutional care. While we agree that many elderly people are more content to remain in their home, this is only possible when there is sufficient home support to allow them to live in their home environment. We are concerned that the province will reduce admissions to both the active care and long-term care facilities prior to the availability of appropriate and sufficient home care support.

We read in the newspapers increasingly of situations where elderly people are discharged from hospitals without the needed transitional care required in the home or in another facility. We support the initiative of other groups to request that hospitals use the funds made available under the quick response project for discharges as well. It would seem that the most vulnerable elderly people in our community—that is, those who have no family and no friends to assist and to advocate for them and who sometimes live in the poorest of conditions—and that's mostly veterans, escape the notice of the discharge planning teams at the hospitals.

We believe the hospitals should be required to review the situation of every elderly patient prior to discharge to ensure that they are being sent home to a situation where appropriate support will be provided. Often home care is made available but not in sufficient quantity to ensure that the elderly person is not at risk. Family physicians should be notified of all discharges of elderly patients.

Veterans are of course citizens of the province and entitled to benefits as part of the general population. They also have special benefits because of their war service, and we feel that this special right under the veterans' health care regulations should be clearly stated in any provincial legislation.

Before I close, I would like to say a couple of extra comments. Maybe Mr Mills would like to ask—my

comments were that he had already asked me.

**The Chair:** He has indicated he wanted to ask you questions, but please—

**Mr Jim Wilson (Simcoe West):** Why don't you do it now?

**The Chair:** Why don't you go ahead, Mr Mills.

**Mr Gordon Mills (Durham East):** Thank you, Jack, for coming here this morning. What prompted me was that I read in your presentation here, "We believe that the legislation enacted by Ontario should provide special mention of the rights of veterans under the veterans' health care regulations." The question that prompts it, and it comes to me in my riding a lot, is where people are in a home together, a man and wife, and the man goes off to hospital for an extended time and there's always this fear that his place won't be there when he comes back and that you have a couple who have lived their lives together who are then separated and never get the chance to live together. I think that's a traumatic experience. I guess that's what really your thrust in that paragraph is.

**Mr Currie:** These are my extra comments that I was wishing to make, that we have this problem in our legion home especially where if a couple is in there and one has to go to hospital and he's there for more than the 31 days, they lose the bed and someone could move into that bed and they may never get back together again because of the placement services. They may find themselves separated for the rest of their time.

**Mr Mills:** So you'd like to see something put in place that would stop that happening, or the possibility.

**Mr Currie:** Yes. Also, we'd like to see more contact, especially out of town, where a veteran comes to the hospital here—not necessarily Sunnybrook, but any hospital—and then they go home. There is no contact between them and the family doctor. Especially if he goes into a nursing home here—say he goes for two or three weeks—and then is sent home, there seems to be a loss. The veteran's up there and he has to then apply for home care, which takes maybe a long time, because nobody knows he's home.

**Mr Mills:** There should be some continuity between—

**Mr Currie:** The hospitals here and the veterans who are from out of town, especially out-of-town people.

**The Chair:** We have just a little bit of time, so I will allow a second question.

**Mr Jim Wilson:** Thank you, Mr Currie, for again presenting to the social development committee. As the Chair said in the beginning, you're no stranger to this committee and we do indeed respect your views on behalf of Canada's veterans. I think a very good point has been raised in the dialogue with Mr Mills here. I'd like to ask the parliamentary assistant, does this bill give any type of guarantee that people won't be put out of hospitals and discharged into the community to the MSA until the MSA has appropriate services in place? What are the mechanisms of continuity provided for in this legislation?

**Mr Paul Wessenger (Simcoe Centre):** I'm going to ask a policy person, Mr Quirt, to reply to that. I think the

whole purpose, of course, is to provide the necessary supports within the community so that they'll be available for people who are discharged. It's certainly an obligation of the discharge planner in the hospital to ensure that those are in place, but there undoubtedly are some breakdowns, and I'm wondering how we deal with that.

**Mr Geoff Quirt:** In answer to your question, Mr Wilson, the bill specifically doesn't address the issue of continuity of service upon hospital discharge. Currently in the system, home care case managers are often located right in the hospital, so that discharge planners in the hospital and the home care program can coordinate the appropriate range of services that someone would need upon discharge.

We fully expect that this will continue and that staff responsible for organizing services from the MSA would be hospital-based in some communities and that, as we pointed out previously, the MSA would be in a position to respond to a variety of needs as well as the professional support needs that people leaving the hospital would require.

**Mr Jim Wilson:** I see the bill advancing the status quo and not making an improvement with respect to the continuity that Mr Currie talked about and Mr Mills talked about. Mr Currie, with respect to your colleagues who presented to this committee in Ottawa earlier, I guess, last month, you've had a chance to, I hope, review the responses that came from the government when they appeared before the committee, and yet again today we're talking about the veterans' rights and ensuring that they're enshrined in this legislation. Were you satisfied at all with the previous responses by the government to your issue?

**Mr Currie:** We were satisfied on a lot of them, but the one that we're talking about now, we didn't see any response to this time when a veteran could go to hospital and then lose his bed, especially where it's a couple. We're concerned about this because there was no real response to that issue at all.

**Mr Jim Wilson:** Could we ask the parliamentary assistant to respond to that here today?

**Mr Quirt:** Not in this bill, Bill 173, but in Bill 101 we established province-wide a placement coordination responsibility so that admissions to long-term care facilities, nursing homes, and homes for the aged are coordinated for anyone who needs access to those facilities. In our policies related to placement coordination, we make an attempt to provide a higher priority for people who are waiting for the facility of their choice. In other words, we allow for people to go into a facility in an emergency situation and not lose their place in line for the facility of their choice.

At the same time, if someone has to leave a nursing home or a home for the aged to go to a hospital for an extended period of time, over 21 days, for the first 21 days their bed is protected. If they are, for example, away for three months in the hospital, they are a high-priority readmission to that particular facility. With that policy we hope that the situation that you're describing, where a couple might be separated because that bed wasn't available again when the person needed to be readmitted,

will be avoided. We'll be monitoring how effective that priority-setting process is in trying to ensure our policy results in the optimal use of facilities and clients being able to get to the facility of their choice as soon as possible.

**Mr Currie:** Since the placement service came on, our Legion home is now full. We've taken on 11 people from the placement service. They're all veterans, it's true, but now the home is full and we're concerned about what happens if one goes out, because there seem to be more and more people needing our care than we had before.

Also, we're worried about our pensioners' apartments. We have low-rental apartments. They rent for \$200 for a couple and \$150 for a single person and the Legion sponsors the rest of the money. We have veterans that go to hospital and they're discharged. We don't even know they're discharged and they come walking down the street and want their apartment back. We think there should be some system where we should be notified or the doctors should be notified that they're going to be discharged. Back a few years ago, we had a fellow discharged who didn't have any clothes at the hospital and he came walking down the street with bare feet. I mean, this is the kind of thing that we run up against which we're concerned about.

On my own, I'm at a loss to understand why we still have to come see you people on all these bills and why the veterans section isn't put in at the onset of the bills. I've been here for 101, 119 and now 173. It's nice to meet with you people, but I would like to see it in there before a bill arises and we have to go over it.

Thank you very much for allowing me to come this morning and I hope that you will give consideration to some of the things we're concerned about.

0920

#### HEALTH SECTOR TRAINING AND ADJUSTMENT PROGRAM

**The Chair:** I call on our next presenters, from the Health Sector Training and Adjustment Program. Good morning. Please make yourselves comfortable. I know you've just come in, and that's all right. The clerk can distribute the documents.

**Ms Shelley Acheson:** I'm Shelley Acheson, the chair of the Health Sector Training and Adjustment Program. Sue Colley is the executive director of HSTAP, and Michèle Dawson is our labour adjustment analyst on staff.

I'm going to primarily read this, but it's relatively short and I think there will be plenty of time for questions afterwards.

We are of course pleased to be here. We are an agency set up to assist health sector employees adjust to restructuring and train for future employment. Originally, the program was set up in May 1992 to assist public hospital employees, and we have since gone through a major expansion of our mandate, structure and governing board.

Our now much broader mandate is to enhance the employment security of all employees in all health sector transfer payment agencies in Ontario—I emphasize the "all" because I noticed this had been brought up at one

point, about whether we serve non-union employees as well as union, and we do—to provide effective job retention, training, labour adjustment and redeployment services. This mandate provides HSTAP with the responsibility not only to assist workers after layoff, but to also work proactively with employers, unions and employees in developing training initiatives to prevent layoffs and retain jobs within the sector.

We're governed by a board of 17 directors, selected at our first meeting on January 31, 1994. We are designed as a joint management-union organization. Eight of the directors are drawn from health employer associations and eight from health employee unions, all of whom you have heard from in one form or another over the past couple of months. I, as the chair, am independently appointed by government, and the funding for the program is provided by the Ontario Ministry of Health.

Like many who have appeared before you already, we at HSTAP support the broad principles embodied in Bill 173, yet remain concerned about the effect the legislation will have on health care workers. The wholesale rationalization of in-home service delivery that the bill envisages also entails extensive workforce adjustment and dislocation. We believe, despite assurances to the contrary, that many health care workers are going to suddenly find themselves either in low-paying, part-time work or in no job at all and without adequate qualifications or skills to adapt to a changing labour market. The impact of these changes is serious for both workers and consumers.

Our first two recommendations suggest comprehensive human resources planning as the best and only way to minimize workforce disruption and allow the redirection of long-term care reform to evolve smoothly and successfully.

Historically, health human resources planning has been confined to the health facility. Comprehensive human resources planning has not only never occurred but, until recent years, has never seriously been contemplated in health care. Fiscal restraint, technological change, an aging population and other shifting health care needs are just some of the signs that our health care system has to change. With these changes already upon us, we are seeing their human resource ramifications, which, if not addressed, have the potential to bring reform to a grinding halt.

We assert that human resources planning must be an integral part of any reform. Planning ideally should take place on three levels: for the whole health sector, for each of the health subsectors—in this case, long-term care—and at the local level—in this context, the district health councils. Although HSTAP has long advocated for a provincial health human resources plan, our recommendations below address the more urgent need for human resource planning at the next two levels.

Bills 101 and 173 focus on the long-felt need for greater coordination and integration in the long-term care sector. Health and social services are to be integrated and coordinated, facility-based and community-based services are to be coordinated, and accountability and funding mechanisms are to be standardized. Only human resources planning remains fragmented.

We maintain that human resource planning must also be given top priority. The bill's changes will mean a fundamental shift in the way long-term care is delivered, and the players in the system need to be ready before this happens. For instance, morale and consequently the quality of care are dependent on workers knowing what their future entails, community service employers need workers who will be retrained to be able to handle more heavier-care clients and to undertake greater case management responsibilities, and hospitals need to know that the appropriate resources and community supports are in place before patients are discharged.

Finally, we argue that greater emphasis on human resource planning needs to be present at the local level as well. As it is now, there is no provision in Bill 173 for mandatory human resource planning. The government has left these issues to be dealt with at the time a potential MSA plan is being considered for approval, as outlined in its policy document *Guidelines for the Establishment of Multi-Service Agencies*. A "human resource strategy" is one of eight criteria that must be present in any MSA plan. Later in the same document, the government identifies five broad areas the human resource strategy must include, yet gives no more guidance as to what exactly is to be resolved, how it is to be resolved and by whom. The five broad areas are volunteer responsibilities and recruitment and retention strategies; collective agreement issues; pay equity and employment equity issues; training and redeployment needs; and employment strategies.

We believe that leaving such major issues to be decided in a fragmented manner by individual DHCs, with no guidance until the approval process, is both inadequate and dangerous. Based on our observations of health restructuring in other communities, it is clear that unless human resource planning is given priority in the restructuring process, the larger objectives—continuity of service, quality and efficiency—will not be achieved.

HSTAP believes a set of human resource planning guidelines should be developed for use in long-term care human resource planning at the DHC level. These guidelines would, at minimum, establish common human resource practices throughout the sector, and could then serve as the foundation for system-wide coordination later. Some coordination might be achieved if the ministry incorporated these guidelines into its approval process for MSAs. The guidelines would ensure a smoother transition process on such key issues as transfer, deployment, evaluation, training and compensation. They would be based on fundamental human resource principles, and some examples are:

- The importance of providing security in employment.

- The importance of providing all employees with fair access to jobs in the system of care.

- The importance of open communication of human resource initiatives, supported by training resources and time to allow workers to assimilate to change.

- The importance of involving unions and staff in non-union workplaces as partners with management in change.

- The importance of maintaining respect for existing collective agreements.

- The importance of support, referral and other transition assistance for displaced workers.

HSTAP would be prepared to offer its experience and resources to help develop a set of comprehensive guidelines to aid the local partners in their human resource planning.

Our recommendation then is that government immediately initiate a process with the involvement of HSTAP whereby requirements for human resource planning will be fully developed into clear and detailed guidelines, and that the adherence to these guidelines be one of the criteria in the MSA approval process.

HSTAP is well placed to offer such assistance. We are the only labour adjustment agency that has the participation of all the major health care partners in the province and a mandate from these partners to enhance the employment security of all health care workers.

For instance, we are currently working to develop basic redeployment protocols to govern worker transition issues. Our protocols will drive our jobs registry, which is a comprehensive database designed to match vacancies with available workers as well as track training needs and employment trends. When the protocols are completed, they will provide additional guidance at local levels where negotiations over redeployment may reach impasse.

HSTAP could also assist the planning process in other ways. For instance, we could provide information on health restructuring solutions in other jurisdictions and subsectors, or contribute additional research support to local planning partners. We could also act as a facilitator to bring the local partners together, or share information on training needs and trends.

#### 0930

**Ms Sue Colley:** Another essential step towards making human resources planning a greater priority entails direction from the Long-Term Care Act to plan at the local level. As we have noted already, there is currently no mention in the act of human resources or labour adjustment matters. Five broad human resource requirements that DHCs must satisfy for approval of their MSA plans are ambiguously outlined outside of this act. This is clearly not enough to avert critical problems during the transition period.

For example, what would happen if a DHC doesn't have adequate resources and decides to relegate human resource planning to the bottom of the heap? Or what if DHCs do not undertake to have fair and equal representation of all workers and employers in the planning process? Who is to monitor this? What level of stringency will the ministry use to determine the appropriateness of the human resource strategy? What effect will the passing of time and the government's desire to get MSAs up and running have on the effectiveness of a district's human resource strategy, as well as the combined effect of all districts' human resource strategies? In short, it is leaving too much to be decided too late.

HSTAP submits that the solution is for DHCs to be

mandated to form committees to develop human resource processes and plans for their regions and their MSAs. We also strongly urge the government to require that all community partners, in particular labour, participate in the development, composition and planning of these committees. We firmly believe, and experience has proven this to be true, that unless mandated, human resources and labour adjustment issues will be relegated to too low a priority and be obscured by other urgent restructuring issues. The result can only be a chaotic and inadequate transition process for workers and for the quality of care they deliver.

We therefore recommend that a requirement to develop human resource plans at the DHC and MSA levels be actually spelled out in the legislation. At minimum, the act should ensure that all community partners—labour, employers and consumers—will be part of a process for developing a human resources committee and plan at the DHC level.

In addition to research on labour adjustment and human resource issues and implementing a jobs registry for job matching, HSTAP is also mandated to provide workers with funding to pursue training. HTAP and HSTAP have been providing this assistance to health care workers since 1992. We believe that training is a valuable key to successful labour adjustment in the long-term care sector. In our three points below, we offer our training recommendations as well as some examples of the initiatives HSTAP is involved in.

For example, our training-to-prevent-layoff initiatives assist employees who are in danger of losing their jobs unless they upgrade their skills or retrain. Training-to-prevent projects are currently developing or under way in seven different locations. For example, in Leamington, over 20 full-time jobs were threatened as a result of the elimination of switchboard operators at Leamington District Memorial Hospital. To prevent layoffs, the hospital submitted a proposal to provide workers with training in basic computer skills and medical terminology in order to create a new job classification called a unit clerk.

We not only have a great deal of experience and knowledge about the kinds of training workers currently want and need, but are also developing a network of contacts with educational providers to discover what training will be needed in the future.

Finally, we're the only agency in Ontario which is undertaking a trends and training needs analysis for the entire health care sector.

We suggest that the government acknowledge the important roles training and education have to play in labour adjustment. We recommend that the ministry stipulate in its operating guidelines to MSAs that ongoing education and training is an essential budget expense.

We also understand that the government convened a working group in 1993 to oversee the development of provincial training and curriculum standards. We believe HSTAP's experience with training issues to date would make us a valuable contributor to the work of this group, and we therefore request that HSTAP be given representation on this resource group.

Finally, HSTAP is concerned that any requirement by the government to upgrade qualifications or skills of long-term care workers be managed carefully and with enough lead time and financial resources for a smooth transition in care and employment.

Our experience at the Creedan Valley Nursing Home in Creemore demonstrates the necessity and urgency of carefully managing any skill upgrading. The nursing home changed ownership in 1992 and the new owner made policy changes requiring all new hires to have their health care aide certificate. The existing 25 employees who do not have their certificate risk layoff if they do not retrain by the end of January 1995.

In these kinds of situations, the government should be providing greater resources to assist workers to receive the required training. HSTAP recommends that any requirement by the government or an employer to upgrade qualifications or skills of long-term care workers be accompanied by sufficient lead time and financial support to enable existing staff to upgrade to meet the new qualifications.

In conclusion, the government acknowledges that human resources and labour adjustment issues are complex and will take some time to resolve, and we agree. That is why we would like to see structures and processes in place that will help ensure that they are resolved effectively from the beginning, and also that HSTAP's experience is not wasted.

Our final recommendation reflects our overall commitment to this process. Currently the act, in section 56, refers to a number of regulations that may be made in the future. Some of these regulations will deal with human resource matters. HSTAP requests a consultative role during the drafting process of these regulations.

We would like to take this opportunity to thank the committee for allowing us to present our recommendations for changes to the Long-Term Care Act.

Maybe you'd like to read the summary of recommendations?

**Ms Acheson:** I think they're there. You've heard them. I won't repeat them.

**The Chair:** Thank you very much. Just to note as well that you have summarized all the recommendations at the end of the presentation.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I think your brief is very important. You are a creation of this government. You are a very important element in this whole transition, in my opinion. About 10 years ago, I was involved in a major restructuring that involved a lot less people than this one and we spent two years amalgamating or complementing the collective agreement process. That whole thing has been quite successful and is still in existence today, and I think it's because we took the time and did that.

I wanted to tell you that on September 12 in Ottawa we received a memo from Mr Doug Jackson. I don't see you as having received that memo. Your name is not on the list of people, so I don't know whether you have it, "Governance of Multi-Service Agencies." In that particular document it says:

"The first MSA board will have to select and appoint a senior staff person"—and I underline singular—"to advise the board on staffing, program and policy matters. This person will assume responsibility for the implementation of the board's policies, as well as the efficient day-to-day administration of the organization."

I would suggest that person is very powerful, and I would suggest the step you have as an intermediary step regarding committees from the DHCs is much more meaningful.

I'd like to ask you, because I feel you've even been humble in your presentation, what your fears are regarding your collective agreements. The other thing I'm very interested in is what your fears are regarding fair access. Could you tell us a little bit more about what your fears are regarding those two very important parts of your employment?

**Ms Acheson:** I think on the collective agreements, perhaps the best way to talk about that would be to use the example of the Windsor reconfiguration. It's always easier to discuss these issues if we have a concrete experience to go by.

**Mrs O'Neill:** Exactly.

**Ms Acheson:** The report that came out of Windsor in the end is quite remarkable, but I think as probably all of you know, the human resources piece of it and the collective agreements piece of it have not been determined finally. There have been some great difficulties there in bringing the unions together. There have been some great difficulties in hospitals going off on their own to do restructuring and to try to work through their collective agreement problems.

While there have been efforts to pull that together and make that work, there have been real difficulties. I think it speaks to some of the things we have in here, which is that without some guidance around these issues and without saying that there are some redeployment protocols that should be used, this is going to happen all over the province and it's going to be one after the other. These issues are not easily resolved. Everybody has to come to the table, and come to the table early, and work it through. I'm not saying we have all the answers by any means, but I think we could provide some guidance and help people come through this.

I guess one of my other concerns is that consultants are often brought in on these mergers and reconfigurations that take place, and that's understandable and important, because people don't have all of the answers. I think a lot of the consultants who are out there have great expertise in the health sector; they don't often have great expertise in labour relations issues. It's really the combination of those things that is needed here. I think that's what we need to look at in order to enable this to happen with less confusion, less chaos and less pain on all sides. That's not to say that it's going to be easy. The transfer issues, the posting issues, the qualifications issues, all of those have to be worked out, but I think if we can make it work in a couple of areas, we can then broaden that out.

**Mrs O'Neill:** Thank you very much. I hope you will

be able to achieve some of the purposes that your board was set out to achieve. It seems very strange that you're not more involved in such a major, major transition.

**The Chair:** I regret that our schedule today is very full and I'm afraid we're going to have to move on, but we want to thank you. I would note as well the additional information and material that you presented us with.

0940

KEN WATERMAN

**The Chair:** I call on Mr Ken Waterman. Mr Waterman, thank you for coming to the committee. We have a copy of your submission, and when you're settled, please go ahead.

**Mr Ken Waterman:** I'd like to take this opportunity to thank the committee for letting me appear before you. I'm here as a former primary care giver. The presentation will outline some facts.

It's most important to read my statement in terms of the overview. It's most important to read my conclusion, what I personally have had to go through as a primary care giver. While I see a lot of good things being done in Bill 101 and Bill 173, I fail to see at this point in time anything being put in place in terms of primary care givers, families. I have given considerable study to both Bill 101 and Bill 173, and I'm sorry, but I fail to see that issue being addressed.

Notwithstanding all the changes that are taking place in the health care system today, what it has done to me personally as a primary care giver, ie, visits to the hospital, has put more of a burden on me. In the last year of my wife's life, 99% of the time I was at the hospital at 6 o'clock in the morning to give her a bed bath. That can be verified by internal documentation. So there's a spillover effect all the way down the line.

My final comment, very brief, is I am literally petrified of what could be in store, ie, my daughter, and her children. What is going to come in the future? Maybe it's a question that cannot easily be addressed today, but I can assure you, with the psychological turmoil that I had to go through in doing what I did do and saving the government and the taxpayers of Ontario I'd say untold thousands of dollars by non-institutionalizing my wife, that a person can only do so much and still be effective in terms of all the other aspects. So I come here hopefully to give some constructive input of what has been seen through the eyes of a primary care giver, not over one or two years, but over 23.

Very short and sweet and to the point. If there are any questions, I'd be happy to address them.

**The Chair:** I wonder if perhaps you might want to note any of the documentation that you gave us, for Hansard.

**Mr Waterman:** The document exhibit B: The only reason that was included was because the process on that was started. For some reason it didn't come through, and I've just done some quick calculations in terms of dollars that did not need to be spent.

**The Chair:** So as we look at the material you have submitted with your presentation, indeed there are ways of going about this in a more efficient way.

**Mr Waterman:** Yes, there is. I would think so. One of those ways is before you in exhibit B, but for some reason we got stalled, so extra trips to the hospital that I don't think were needed.

**The Chair:** Okay. Because your presentation has been brief, I think we can allow for a couple of questions on this, as I know members are looking at the material that you've attached.

**Mr Jim Wilson:** With respect to exhibit B, I gather you were paying out of pocket for the drug?

**Mr Waterman:** No.

**Mr Jim Wilson:** Could you explain exhibit B to me, because I'm not quite sure what you're getting at there.

**Mr Waterman:** Exhibit B is the final letter that was faxed out of my local MPP's office, whose name is on the bottom, to the drug benefit section of the Ministry of Health. Briefly, it states that the original documentation was sent out by my wife's general practitioner on or about April 15, 1992.

**Mr Jim Wilson:** That was a request for funding under the Ontario drug benefit program?

**Mr Waterman:** That's right, so that the procedure could be carried on at home as opposed to going into the hospital for five days and tying up a bed.

**Mr Jim Wilson:** Right.

**Mr Waterman:** From my conversations with the doctor, he saw, in terms of safety, that there was no question that the procedure itself could be carried out in the home.

**Mr Jim Wilson:** So your physician filled out a section 8?

**Mr Waterman:** That's correct.

**Mr Jim Wilson:** How long did it take for approval? Was approval given?

**Mr Waterman:** No.

**Mr Jim Wilson:** That's your point.

**Mr Waterman:** That's the result. That's my point.

**Mr Jim Wilson:** So your wife remained in hospital?

**Mr Waterman:** No, she had to go about every six weeks for a five-day trip because of the bladder irrigation that was what the specialist ordered.

**Mr Jim Wilson:** So did you ever get a response prior to your wife's passing away?

**Mr Waterman:** No, that's why that letter's there.

**Mr Jim Wilson:** How long, again, was it?

**Mr Waterman:** I originally faxed an inquiry on or about May 1 to find out the status.

**Mr Jim Wilson:** Of 1992?

**Mr Waterman:** That's correct. Finally, in November 1992, that was my end letter, sir.

**Mr Jim Wilson:** Your MPP should have raised this one in the House. That's a ridiculous amount of time for an ODB approval that never did come.

**Mr Waterman:** Like I say, the numbers, in terms of the VON, in terms of the current fees that were in effect by OHIP, those are the exact numbers. So to me \$11,200 is a substantial saving.

**Mr Jim Wilson:** Can I just ask, because we haven't had a lot of people who are in or were in your position as a primary care giver appear before this committee—and I am sorry to learn of the passing of your wife—

**Mr Waterman:** No, I don't expect an apology. That's the way, unfortunately, it worked out. If it had worked out on the positive, that's what the saving would have been to the province of Ontario in terms of health care costs. There's no big mystery about it.

**Mr Jim Wilson:** Is there anything else about the system—it sounds like your wife did have some VON assistance.

**Mr Waterman:** Oh, yes, I had good support services. That's all in the documentation. If you refer to the gentleman in the statement of overview, you will find quite a file.

**Mr Jim Wilson:** If we were to ask the assistant deputy minister, Michael Ennis.

**Mr Waterman:** That's right.

**Mr Wessinger:** If I might just rephrase what your concern is, so that it's clear to all members of the committee, on the record, it seems to me that from the presentation you're making you're saying no matter how good a long-term care program you have in effect with respect to providing care in the community, if the other aspects of the health care system don't work in conjunction with, in this case, the Ontario drug—

**Mr Waterman:** Not in all cases, no.

**Mr Wessinger:** That's right. In other words, the problem here was with the way the Ontario drug benefit program was working, and we need to ensure that the whole system is integrated.

**Mr Waterman:** Yes, but it's going to take time. That's where I'm coming from at this point in time. I don't have anything more to do with it.

**Mr Wessinger:** Right.

**Mr Waterman:** I've got two documents that support—for me, it's over and done with. But my concern is for my daughter, her children. If I'm concerned about that small group, then intangibly it spills out over to—if you people have any children or grandchildren, it's going to affect them one way or the other, if they're faced with this type of a situation.

**Mr Wessinger:** Yes, I understand.

**Mr Waterman:** To me, the way I look at an incurable disease, it's no good no matter how you cut it, and it doesn't matter what the disease is, because it's not nice to see somebody you love die slowly before your eyes.

**The Chair:** Mr Waterman, I want to thank you very much for coming before the committee. As was noted, to have someone who's gone through the particular experience that you have is very useful for us as we continue in our deliberations.

**Mr Waterman:** My final comment is that I hope I see something in black and white in terms of rights for primary care givers.

0950

**Mrs Barbara Sullivan (Halton Centre):** I wonder if the Ministry of Health could do a briefing note for

members of the committee with respect to what protocols or clinical guidelines exist for approvals of medical procedures that can be done in the home and how they are integrated with other parts of the system. I think that Mr Waterman's submission to us is a very important one because it really tells how the system actually works, and it turns out to be a non-system. If we could have that kind of documentation, I think it would be helpful for us all.

**DON MILLS FOUNDATION  
FOR SENIOR CITIZENS**

**The Chair:** I call on our next presenters, from the Don Mills Foundation for Senior Citizens Inc. If you would be good enough to introduce yourselves, we have a copy of your submission.

**Mr Roy Arendse:** My name is Roy Arendse, and I'm a member of the board of directors of the Don Mills Foundation for Senior Citizens Inc. Before beginning, I would like to introduce you to the other two presenters, Catherine Brookman, vice-president of community services for the foundation, and Carmel Smith, a client of the foundation.

Given the time constraints, we have submitted in writing a more thorough summary of our concerns for your consideration. Our presentation will begin with a brief overview of the Don Mills Foundation. We follow this with areas of the legislation that are of concern as well as the potential impact of this legislation from the perspective of one of our clients, Carmel.

The Don Mills foundation for Senior Citizens Inc is a not-for-profit community organization of volunteers and professionals committed to serving the wellbeing and social needs of seniors through a broad range of services and a commitment to a continuum of care. The Don Mills foundation operates three facilities in the Don Mills area: Taylor Place Senior Adult Centre, Taylor Place Community Services and Thompson House Home for the Aged.

Taylor Place Senior Adult Centre was opened in 1976 as an elderly persons' centre, offering a range of social, recreational, educational and health programs, serving over 1,000 seniors annually. In 1983, Taylor Place expanded its services to include home support programs. The client intervention and friendly visiting programs were among the first home support services, which have more recently been expanded to include a frail elderly day program, an Alzheimer's day program, a respite care program and a southeast Asian Meals on Wheels program. The home support programs serve more than 1,500 seniors per year.

Thompson House is a 136-bed home for the aged which was opened in 1969, providing both residential and extended care services.

The range of services offered by the Don Mills foundation includes social work; information and referral; Meals on Wheels; transportation; care giver support groups; adult day programs, frail elderly and Alzheimer; home maintenance and repair services; friendly visiting services; security check service; social and recreational services through the senior adult centre; health and special services in chiropody, a legal clinic, a tax clinic and nutritional services; homemaking; home help; respite

care services; a long-term care facility.

The foundation has been providing one-stop access to care through the continuum of services it provides: home support services, community support services, personal care services, social recreational services, as well as institutional services. Many of the components of Bill 173 are not only supported but have been implemented by the foundation. As an example, the Don Mills foundation has operated a centralized access process for all seniors in the Don Mills community since 1988. This process includes information and referral services to all the programs and services of the foundation, as well as a comprehensive assessment, case management and case coordination service.

The Don Mills foundation is pleased to have this opportunity to make a presentation to the Legislature's standing committee relating to Bill 173. The foundation has been an active participant in the Redirection of Long-Term Care and Support Services in Ontario with the support of dedicated clients, volunteers and staff. The foundation applauds the efforts of the government over the past two years in working towards building a new long-term care system.

The foundation supports the concept of multiservice agencies and the principles on which they will be developed, namely, to provide one-stop access to care; to amalgamate assessment, case management and service delivery in a single MSA; to achieve administrative efficiencies; to develop an integrated, complementary human resources process; to ensure greater consumer participation and control in planning delivery of services; to build a system that delivers service on a not-for-profit basis; and to develop equity of service delivery across the province.

The Don Mills foundation mirrors these principles not only through the continuum of services it provides but also through an overall operational practice. Over the past 25 years, the foundation has been a leader in the provision of services to seniors and continues to strive to meet the growing needs of the community. Community consultation, collaboration and cooperation have guided us in the past and will continue to guide us in the future. The foundation supports the principles of Bill 173 and through its comments on Bill 173 hopes to assist in the actualization of a truly integrated long-term care system.

The foundation is concerned with the following main areas of Bill 173: definition of services and new terminology; social work services and the functions of intake, case management, information and referral; social or recreational services; health and health promotion; and board composition.

The foundation appreciates the opportunity to share our perspective on the legislation being examined and looks forward to the continued partnership with government and communities in the implementation of long-term care reform.

I would now like to ask Catherine Brookman to take you through specific areas of the legislation.

**Ms Catherine Brookman:** I will begin my comments in the area of board composition and governance. The

foundation is pleased that one of the factors the minister shall consider in deciding whether to designate an approved agency as a multiservice agency is board composition. It is essential that the board be reflective of the diversity of the persons to be served by the agency in terms of age, gender, disability, ethnicity and spiritual factors and that clients, care givers and volunteers be included in this. It is also essential that the board reflect the level of expertise needed to guide and direct an agency, such as financial expertise, human resources expertise and, as mentioned in part VI, clause 11(2)(b), persons experienced in both health and social services fields.

Therefore, we are recommending that in part VI, multiservice agencies, subsection 11(2) be revised to include clients, care givers and volunteers. As well, we would like to see inserted an additional paragraph that would indicate that the agency's board of directors will include persons experienced in the areas of human resources, financial management, legal matters and other related fields which will assist in the governance role of the board.

#### 1000

The foundation would encourage the minister to reflect on the governance issue for those organizations that provide a continuum of care through services identified as outside of the multiservice agency. This would include organizations that, along with providing the core basket of services, may also provide, for example, residential care through a home for the aged or supportive housing and/or even a senior adult centre.

To carve an organization into separate entities does not support the principles of the reform. From the perspective of a client, an organization that provides the core basket of services and also a long-term care facility, for example, strengthens the principles related to a continuum and one-stop access. Likewise, it would be wise to avoid severing the continuum of services that has been developed through the mandate of the community and through the time and energy of thousands of volunteers who have been proactive in planning for their future.

The next element that I would like to bring to your attention is the section of the bill pertaining to definitions. The legislation is not consistent in the presentation of definitions of terms. Definitions have not been provided for "friendly visiting," "security checks" or "reassurance services," "home maintenance and repair" and "social or recreational services." As well, an essential service, respite care, has been lumped in with care giver support services. There is more detail provided for homemaking and personal support services, yet professional services such as social work have not been defined.

Bill 173 introduced new terminology. Personal support services were previously known as "homemaking," and "homemaking services" has replaced the previously referred to "home help services." The distinction between "personal support services" and "homemaking services" is contrary to long-term care reform in general and specifically to the purposes of this act, as identified in part I, purposes of the act, clause 1(c), page 3, that is, "to

recognize the importance of a person's needs and preferences in all aspects of the management and delivery of community services."

Clients have indicated to both government and service providers that the proliferation of different workers in their homes has been unnecessary and confusing. Agencies have addressed these concerns over the past five years through the delivery of these services by a generic worker. This combines health care aides, homemakers, home support workers, respite workers, home helpers and attendant care workers. The services outlined in the act under part II, interpretation, subsections 2(5) and 2(6), are in most agencies provided by the same worker. The delineation of these two services separately is a disservice to the client and alarming for the agencies that have developed comprehensive holistic training programs to support the generic-worker-concept mode of delivery of service.

Therefore, we are recommending that clear and well-developed definitions for all services be provided to ensure consistent and equitable access to all community services across the province. Service providers must be involved in the development of these definitions, as they have been doing work in this area for many years through provincial organizations such as the Ontario Community Support Association and the Older Adult Centres' Association of Ontario.

The other recommendation related to this area is that the distinction between homemaking and personal support services be eliminated and that whatever term used to describe these services also include respite care services.

My final comments are on the area of social work services and information and referral. The provision of social work services is an integral part of the long-term care system. The multiple needs associated with one's physical, social, psychological and spiritual wellbeing need to be taken into account when assessing clients. The role of a social worker is more than that of a case coordinator; it is more than managing resources; it involves case management. The role of a social worker is akin to that of a travel companion, rather than that of a travel agent. It is the travel companion who walks along with the client through the journey of care, providing support, guidance, assistance with instrumental tasks of daily living, advocacy, financial management, supportive counselling, as well as linkages to other care providers.

Community-based social work to seniors and the disabled is presently provided by selected home support programs such as the client intervention and assistance program. These services are not recognized in the bill, and therefore we would encourage government to ensure that the grass-roots, task-oriented services provided by this program are included in the basket of services, either through the definition of social work services or as a separate service.

Currently in Metropolitan Toronto the functions of information and referral are provided through the client intervention and assistance program. For those agencies that do not have a client intervention and assistance program, these functions are performed by the independent programs themselves, which often results in a

duplication for the multiservice client.

The absence of a defined intake service is the largest and gravest oversight of this bill. The success of the functional aspects of the reform depend on this service. The principles of long-term care reform rely operationally on an intake service. One-stop access, a single point of entry, consistency and availability are essential elements to intake and the success of the reform.

Traditionally, intake has been delivered on the backs of other service programs, which has resulted in multiple assessments, duplication, inconsistency, administrative complexity and the misuse of staff and funding resources. In order to simplify and improve access to a continuum of community services, which is one of the purposes of this act, intake needs to be included in the community support services section or defined under the definition of social work.

Therefore, we make the two following recommendations: that the current functions provided and performed by the client intervention and assistance program must be incorporated into this bill, either within the definition of social work services or as a distinct service, and that the essential functions of information and referral be incorporated into an intake service, either within the definition of social work services or as a distinct service.

**Mr Arendse:** At this time I would like to ask Carmel Smith to speak to you about her experience with the foundation, which reinforces the concerns that Catherine has put forward regarding the absence of definition of social work and the need to consider the importance of the functions of the client intervention and assistance program.

**Mrs Carmel Smith:** I was introduced to Taylor Place about seven or eight years ago. At the time, I was in hospital, and I can't recall if it was a social worker or a head nurse, but somebody came to me and told me about Taylor Place. They said it was a very social type of organization and that I would enjoy it. They told me various things about it and gave me the phone number.

At the time I said, "Yes, that sounds fine." I didn't think, "I won't bother," but I didn't get overenthusiastic about it. However, about 10 days to two weeks later, somebody did call me from Taylor Place, a representative, and she asked if she could come to my home to see me, which she did, and which I was terribly pleased about. She explained Taylor Place.

At that time, which was seven or eight years ago, they had a dinner on a Sunday once a month. They also had movies in the afternoon; they would pick you up and take you there. I was very pleased about it. They told me I would be picked up, at a small fee, but that was fine. I enjoyed that.

Then I got better and things began to look up and I went into volunteering for Taylor Place.

I still kept up my association with them. Then about three years ago I was going through a bad time in my life. I was in hospital and my doctor said, "How is your social life?" I said, "Zero." So he said: "Well, we have to do something about that. Do you know of any place? Are you attached to a church group or anything?" I said,

"No." He said, "Any other place you know?" I said, "Yes, I do know Taylor Place." "Well, do you know anyone there?" I said, "Yes, I do." "Can you get in touch with them?" So I said, "Yes." He said, "I also want to speak to them."

**1010**

I phoned Taylor Place and I spoke to the same lady. I guess I can mention her name, Ronnie Brannigan. I explained things to her and she said, "Well, I doubt if I can get out, but I will send"—to cut a long story short, somebody came up to the hospital to see me. Also, there was a lot of information to give me because in that time Lesmill had opened, which is a day program.

She explained all this to me: "You can come in the morning and have lunch, and we've all sorts of things going on: crafts, arts and outings and all this. You will have your lunch and we will pick you up and take you home," which to me was fantastic. She did all this in the hospital. This was all arranged before I left. Also, she had spoken to my doctor and had spoken to the social worker at the hospital and they were very, very interested, and all the rest, about it.

I am still there and I enjoy it thoroughly. But I think my point is that if you're not feeling well or you're down or you've lost a spouse or something like that and you hear about Taylor Place, you're not inclined to go, as much as it would appeal to you. I think the important thing is somebody coming to you. It makes it more personal and it makes it more caring, that somebody cares about you at this particular time. I think it's a very good introduction to Taylor Place.

**Ms Brookman:** Carmel was specifically speaking about her experience through the client intervention assistance program.

How are we doing for time?

**The Chair:** We're all right. We're getting a little close.

**Ms Brookman:** I think I will skip the formalities of a conclusion and perhaps open it up.

**Ms Jenny Carter (Peterborough):** Thank you very much. I certainly think that your organization does a wonderful job. But I'm a little puzzled that you're saying that through what is proposed in this bill we're not getting integration and a continuum of services, because it seems to me that is what this bill is all about and what, hopefully, we are getting.

Although your particular organization may be integrated, if you look at the whole picture, we have a vast number of agencies and organizations, all doing a good job, but there is fragmentation, there is difficulty in a client knowing who to go to, what is available and so on.

What we're looking at here is making that one point of access so that a person can just make that one phone call and find out what the whole range of possibilities is and also making sure that range is available over the whole province. I know that in some places we have excellent coverage already.

Of course, when we look at this Price Waterhouse report, that is based on the assumption that we're going to save a lot of money through better integration, which

we'll then be able to be spend on the front lines of service, which is what we all care about.

Also of course, there is going to be a lot of flexibility in the sense that governance will be from the local level, from local boards, and not from the top. So I wonder whether some of the omissions that you see in the bill are rather things that are being left for the local decision-making process as to just how it's going to be done in a given area. I just wonder if you could comment on those points.

**Ms Brookman:** I'd like to comment first on your remark regarding the Price Waterhouse study. If it's the same article that I read a couple of weeks ago, I would be a little cautious about quoting that. I understand they did a study for about \$6,500 and they talked in that study about integration and changing the long-term care system, which will in effect correct some of the 30% of administrative inefficiencies, which is a gross overgeneralization. When you have an organization, for instance, that is strictly delivering Meals on Wheels and you have a coordinator who is also the executive director and the 30 other staff are actually volunteers, then you pretty well have mostly administrative costs. So I'm a little concerned about the generalizations that were made in that article.

With respect to the continuum, I certainly concur with you that across Metro and certainly across the province perhaps the continuum of services that are provided under the Don Mills foundation are not provided in such a format in other areas in the province, and I certainly believe that integration and coordination are really needed and that if you have organizations that are next door to each other and perhaps servicing the same clientele and providing the same services, then maybe there's a rationale to look at sharing of resources and doing things. But that's not to say and I would be very hesitant to conclude that they would be doing something incorrectly, because they may be providing an excellent service. The fact that they are next door, there may be actually a very good administrative and effective rationale for that and it may in fact prove to be cost-effective.

But an organization such as the Don Mills foundation, which is servicing a catchment area of approximately 120,000 constituents now, 16,000 of those being over the age of 65, does provide the one-stop access and not only for the core basket of services. We also have a home for aged and a senior adult centre so that people who are well come.

As Carmel has pointed out, her doctor asked her, "How's your social life?" because he recognized that social and recreational experiences and opportunities are part of wellness. That's part of the preventive mechanism and part of the integration that I think—and we've spoken to this in our deputation but we weren't able to talk about it here today because of time—is really an integral piece and needs to be included.

**Ms Carter:** Definitely.

**Ms Brookman:** So the person comes into the organization through the senior adult centre, and then as their needs escalate, they perhaps receive some home support services. Then maybe down the road they'd like

to move into a facility, and it just so happens that we do have that facility onsite.

I think it would be very detrimental for the community if the implications of this bill are that the Don Mills foundation would have to separate into three separate entities. Carmel asked me this morning: "You know, I'd like to look into getting into Thompson House. How do I do that and who do I talk to?" I said, "Well, things have changed a little bit and we can certainly talk about that."

**Mrs Smith:** Sure did, and it surprised me.

**Ms Brookman:** But from the perspective of a client, they've been in an organization, they know it well, they're familiar, they're comfortable and they just walk through the organization. I certainly hope the implications of this reform do not tear down organizations and structures that facilitate integration.

**Ms Carter:** We're certainly looking for a continuum of care, and I hope and believe that is part of the objective of what we're doing. Of course, it does say in the act, section 20, "When a person applies to an approved agency...the agency shall assess the person's requirements;...for each person who is determined to be eligible, develop a plan of service," and so on, so there is going to be a very careful and personalized assessment of each individual.

As you said, we have had a system where a person could be assessed over and over again, and we're trying to make sure that only happens once, that it's done thoroughly, that the person has input into what they want and what their preferences are. Hopefully, they will have access to that continuum and will be able to be placed just exactly where they wish on it. I think we really want the same thing and you're just concerned that the bill may not be providing that.

**Ms Brookman:** Which is a big concern.

**Ms Carter:** Obviously. We feel that it is.

**The Chair:** The parliamentary assistant wanted to comment on a couple of points.

**Mr Wessenger:** Thank you very much for your presentation. I'm certainly interested in seeing what comprehensive services you provide. You certainly fit very well in that integration concept.

Two points of clarification: First of all, I'd just like to clarify for you that the definition with respect to services in no way is any policy indication that there should be anything other than a generic worker. In order words, the concept is that the homemaking services and the personal support service should be provided by the same worker. I just wanted to assure you on that.

Second, with respect to your concerns about the client intervention and assistance program, it's deemed by the policy people, the draft of the act, that that's included in the case management definition, so there's certainly recognition that this is a very important part of the whole case management process.

**Ms Brookman:** Thank you.

**The Chair:** Thank you again for coming before the committee. At an earlier time I had the pleasure of

visiting Thompson House and Taylor Place and I know all you've said about it is the way it is, and I wish you all the best in the future.

#### 1020

##### ONTARIO COMMUNITY SUPPORT ASSOCIATION, AREAS 5 AND 6

**The Chair:** I call on our next presenters, from the Ontario Community Support Association, Areas 5 and 6. Gentlemen, welcome to the committee.

**Mr David Wartman:** My name is David Wartman. I'm the president of the Ontario Community Support Association. With me this morning is Dan Stapleton, our executive director.

There has been a variety of interpretations, and I might add misinterpretations, of the position of the Ontario Community Support Association with respect to this piece of legislation. As a consequence, the members of areas 5 and 6 and the board of directors of the association felt it was important that we use the time this morning to attempt to clarify our position. I think it's safe to say that we continue to support the bill in principle but we have some serious reservations about elements of the bill as it stands right now, and without changes, our support would not be forthcoming.

We're pleased to have been given the opportunity to make a final presentation to this committee regarding Bill 173, the Long-Term Care Act. The Ontario Community Support Association, which represents over 300 agencies providing Meals on Wheels, homemaking and home support services, has presented in each of the regional centres with local concerns, as well as a presentation of the association's collective views.

Our detailed response to Bill 173 was previously submitted. However, as I said, we wanted to take this opportunity to reinforce certain key areas based on our understanding of the discussions during the public hearings to date.

There's no question that reform of the long term care system is needed, and we are pleased that the government has taken this task seriously and introduced legislation to guide the process. We support the purposes of the legislation such that a broader continuum of care is made available, that more of an emphasis is placed on promoting health, that there is an attempt to integrate health and social services, that access to a continuum of community services is made easier, and that the quality of community services will be improved.

However, we have concerns that the bill, in its current form, will not meet consumers' needs or expectations because of its overly rigid and prescriptive nature. In fact, OCSA cannot support Bill 173 unless it is amended. What we had hoped for was a blending of the positive components of the health system with its emphasis on accountability, fiscal systems, quality assurance and service standards with those of the social services system, which is marked by adaptability and the capacity for informality along with innovation and creativity.

However, this bill seems to lack the advantages of the social services system in favour of a level of inflexibility with rules and procedures that was neither expected nor

needed. We would like to therefore outline our specific concerns.

**Multiservice agency:** We feel that the MSA model as currently outlined in the act, which involves a consolidation of service provider agencies into one organization, is too rigid. OCSA cannot support the MSA model as set out in the act, but rather we support the alternative MSA models which endorse the principles outlined in the purposes of the act and are a result of a community planning process.

In many areas of the province the consolidated MSA model is appropriate, and in fact in several communities service providers and consumers are actively planning this type of organizational arrangement. This proactive planning should be encouraged and the momentum for change maintained.

However, in other communities the consolidated MSA model may not be appropriate for those communities' needs and unique circumstances. We do not feel that only one model should be implemented in every community, but that flexibility in model design is required.

**OCSA's CCCO model:** Our association in 1992 recommended an organizational model for the government's consideration called the comprehensive community care organization. We understood that in the hearings which have been conducted since mid-August, the government and others have cited our organization as having recommended the MSA model. We feel we need to clarify this point because what is written now in the act is not what we recommended.

Specifically, what we said was:

"The plans to establish the service coordination agency structure should be abandoned and replaced by the development of not-for-profit, comprehensive community care organizations.

"The government should immediately establish an innovation fund for the purpose of fostering development of no less than 10 demonstration models of comprehensive community care organizations for long-term care.

"CCCOs should provide assessment, case management and a full range of in-home and community services to an identified population or community."

In that submission, we recommended that collaborative community planning was necessary in order to bring about the needed changes to the system. We later recommended that organizational structures should be developed using a gradual planned and phased approach over a period of years. This would therefore allow the development of CCCOs in areas where there was support, and tailored to the unique needs of the local community, with the rate of development being based on the community's current level of integration and ability to implement such a large systemic change.

Our feeling now is that the legislation's one model for all of Ontario may involve too much of a systemic change in too short a time period. The principles of community development require that stakeholders which are involved in the planning process need to come together as equal partners with a commitment to and ownership of the process. We have concerns that these

principles are not being observed in the planning approach being used in many communities, and we recognize that some communities are not ready for an integrated MSA model and in fact are working to develop alternatives which will meet their community's needs.

**Mr Dan Stapleton:** A number of organizations have advocated during the hearings for the removal of section 13 of the act which restricts the amount of services an MSA may purchase from other service providers to 20%. OCSA is prepared to support this recommendation but with a proviso: OCSA endorses the removal of the purchase of service restrictions from the act and further recommends that community boards be empowered to provide or obtain their services from the not-for-profit sector unless this sector cannot provide these services.

Many groups have also recommended the removal of the four-year exemption period since it is felt that this may constrain some communities along with some interim models which may be meeting consumers' needs. We feel that if this time limit is removed in conjunction with more flexible MSA models being allowed, incentives will be needed to ensure that the goals of reform are achieved. Government needs to support communities with appropriate resources and objective facilitation, therefore fostering community development.

Also there will need to be benchmarks established so that communities can be assured that the reform of the long-term care system is indeed proceeding. Indicators of quality, consumer satisfaction and cost-effectiveness would need to be established and reviewed on an annual basis. We do not want to lose the positive momentum which the reform process has already engendered at the expense of introducing flexibility. Reform must proceed, but communities need to be empowered to ensure that the reform system meets their needs.

Human resources issues for both employees and volunteers: OCSA is concerned that the needs of the current employees and volunteers in the system have not been adequately addressed by this bill. In our previous submission, we went into some detail regarding this point. But let us emphasize our recommendation.

OCSA recommends that client continuity and respect for the relationships between existing employees and consumers of service should be paramount. Consequently, employee transfers to new agencies should be seamless with no break in employment or client service. All employees of not-for-profit community support agencies should be guaranteed comparable positions in new service delivery structures without loss of seniority.

1030

Our association's agencies utilize over 50,000 volunteers in delivering, governing and raising funds for the various community support services. They are the backbone of our sector and therefore must be recognized. The transition to an improved service delivery system will involve many changes regardless of the type of organizational arrangement that ultimately is implemented in communities across Ontario.

We feel that volunteers need to be nurtured and planned for. They are motivated by an array of factors

and cannot be shifted organizationally away from their work without careful planning, or we risk their loss in the transition process. What is required is the maintenance of linkages between volunteers, their communities and the agency staff who work with them.

Specifically, OCSA recommends that there be recognition of the role of volunteer in the body of the legislation. We further recommend that volunteer management in regulation 11 should be expanded to require MSAs to develop and implement a plan for the recruitment, training, scheduling, supervision, retention, recognition and expense reimbursement of volunteers.

The last point we wanted to make concerns the cost of the new system. When we embarked on the reform of the long-term care system, the primary emphasis was on simplified, equitable access to services, reductions in fragmentation, enhancements in the number and quality of services and consumer-centred care. We did not expect that the \$647 million earmarked for the reform process would face so many cost pressures which have eroded the government's ability to expand services; for example, earlier discharges of patients from hospitals have led to higher expenditures on acute home care programs. We have also experienced increased costs associated with pay equity.

What has recently emerged as a result has been a focus on cost cutting as one of the primary arguments for organizational change. Claims in this regard have been made in other presentations to the standing committee. We feel it is important to respond and clarify our association's views. A recent report released by the Senior Citizens' Consumer Alliance for Long-Term Care Reform included a comparison of the administrative components of the current and proposed home care systems, prepared by Price Waterhouse management consultants. This report, because of its simplicity, implies that community-based programs are currently administratively top-heavy and are operating inefficiently.

We all recognize that we can improve our efficiencies as we strive for quality. However, what has not been recognized, because it is buried in the report's appendices, is that the administrative costs of community support programs such as Meals on Wheels, homemaking and home support services are already, on average, below the administrative cost being suggested for an MSA. Our agencies are run on a shoestring with minimal administrative overheads.

If you factor in the dollar value of the 2.5 million hours of services delivered by volunteers in our agencies last year, at an average community support worker's wage rate, the real administrative cost drops significantly. Currently, in many smaller agencies, executive directors do some front-line work, and bookkeeping and accounting services are often handled by volunteers. Will these flexible and donated services be as inexpensive in an MSA?

The study attempts to prove that administrative costs in MSAs will be lower and makes the assumption that 70% of the current costs can be recovered through economies of scale. This seems to us to be wildly optimistic and in fact the basis for this assumption

remains unexplained in the report. We feel that in some communities an integrated MSA can result in cost savings. However, this is an area that the government has not yet addressed in its analysis of service delivery models.

Enhancing quality and ensuring equitable access to services carry a pricetag. We have argued that more funds need to be fed into the community support services system in order to handle increased service demands that have come about because of the increasing aging population and shifts of clients from the institutional system. The shift to the community needs to include shifts of funds as well as clients. Other than recent increases to the integrated homemaker program, we have yet to see these new funds.

We therefore caution that as the standing committee makes decisions regarding this bill and its recommended organizational components, it should treat the findings of this report with scepticism.

**Mr Wartman:** We have attempted to highlight some of the key concerns that we have heard from our members since the legislation was introduced in June.

In summary, OCSA cannot support Bill 173 in its current form unless it is amended. Flexible MSA models, which are a result of a community planning process and are based on the community's needs and unique circumstances, should be encouraged. Restrictions on the purchase of services outside the MSA need to be relaxed, provided community boards provide or obtain their services from the not-for-profit sector unless this sector cannot provide those services.

The needs of current employees and volunteers in this system must be appropriately addressed in transitional planning, the potential cost of the new system should not be underestimated, and new models will need to be planned and analysed carefully.

We thank you for the opportunity to present these concerns and recommendations on behalf of our association's members. We look forward to continuing to work in partnership with our health and social service colleagues, and with the government, to bring about the redirection of long-term care.

**Mrs Sullivan:** I appreciate this particular presentation, which has clarified a number of the issues that, as you know, became a matter of contention during the course of the hearings. We also appreciate having your analysis of the Price Waterhouse report, which was presented by the consumer alliance. We feel that Price Waterhouse did not reach its usual standards of quality in preparing that report, and we will be having interviews with them, but we just think they were way off the mark.

I wanted to specifically ask you about two issues. On page 3 of this report, you speak about incentives that should be provided to ensure that the goals of long-term care reform come to the fore, if the four-year time limit for an interim process is removed. I'd like to know if you could describe the kinds of incentives you feel would ensure that long-term care reform would still stay on the road, while allowing the flexibility for different models and different time lines in moving into another model.

**Mr Wartman:** I think one of the concerns that our board experienced in recommending this change was the concern that the reform process would go off the rails, because we felt that one of the advantages of the four-year time limit was that it keeps it within a time period and maintains the momentum. We feel that if you combine the relaxing of the time period with more flexible models, there needs to be probably financial incentives. We haven't gone into a lot of detail with regard to the details of that. I feel we would need to have some more discussion about that.

One of the things we felt, too, was that in terms of the planning process, the way in which planning is being done oftentimes doesn't put the partners on an equal playing field, those that are involved in the planning at the DHC steering committees, and we feel there needs to be more resources and an objective facilitation of change so that the smaller players, such as the agencies that belong to our association, feel that their issues are being heard and they're not being railroaded by other power brokers from the past.

**Mrs Sullivan:** Right. The other issue also in the same paragraph that I think merits a lot more attention than it's being given is your discussion of the evaluative mechanisms, the "indicators of quality consumer satisfaction and cost-effectiveness need to be established and reviewed on an annual basis." Would you like to speak more on that?

**Mr Wartman:** Maybe I could just mention on that point, we thought that if there's a way of establishing benchmarks so that say on a yearly basis, these indicators of quality cost-effectiveness and so on are reviewed—so that a community, which is the broader community that consists of not only the service providers but the consumers or potential consumers, can see whether or not that local MSA is meeting the needs and is achieving the goals of reform.

**Mrs Sullivan:** We raised this question with Dr Naylor when he was in the estimates committee with respect to evaluative mechanisms that would be appropriate for services that are delivered in the community or in the home, and my understanding is that there is some work being done at ICES and it's probably very worthwhile to follow that up to see where that is going. That's useful.

**Mr Wartman:** Yes.

**Mrs Sullivan:** Thank you.

**The Chair:** Thank you very much for coming before the committee. I regret, again, because of our schedule we can only go with one questioner, but we appreciate all the material that you've presented.

1040

#### COMMUNITY AGENCIES IN PARTNERSHIP

**The Chair:** I call on the representatives from the Community Agencies in Partnership. I want to welcome all of you to the committee.

**Ms Sandra Sillcox:** My name is Sandra Sillcox. I'm a resident of York region, past president of the Alzheimer Society of York Region and am presently chairman of Community Agencies in Partnership, which will be referred to as CAP. On that behalf I am making this presentation this morning.

I have with me Deborah Egan, who is the executive director of CHATS, Jackie Catto, who is the president of VON in York region and Susan Taylor, who is with the regional municipality of York, community services department.

**The Chair:** The Chair is always happy to welcome representatives from York region.

**Ms Sillcox:** Good. Well, we feel comfortable in your environment. Thank you.

CAP is a network of community service providers who provide long-term care services in York region. It was formed in June 1993 by board members who voluntarily came together in support of simplifying access and coordinating services within the long-term care sector.

The membership, and a list is attached, has expanded, and it now includes both senior staff and board members of the following agencies: the Alzheimer Society of York Region, ADAPT, which is the Association for Differently Abled People Together, the Canadian Red Cross Society, Community Home Assistance to Seniors, Ontario March of Dimes, Palliative Care Services of York Region, the VON, York region community services department, York region home care department and York Support Services Network. Several members have been involved in preparing this presentation, and many are represented and have been introduced to you today.

The purpose of CAP, as defined in the terms of reference, is to foster an informal partnership of community service providers to allow them to collaborate on the delivery of health and social services within the long-term system in York region.

CAP is in support of the reform of the long-term care, and we present to you our concerns about Bill 173, An Act respecting Long-Term Care in Ontario.

The role of the board of directors: On the issue of governance, we find the micro-management approach of Bill 173 most disturbing. Specifically, subsection 56(1), the nature of the decisions to be made centrally, appears to question the need for, and the role and function of, a community-based board of directors, that is, of the local agencies. In part VI, the power and authority for operating the MSA appears to be with the ministry. Will this top-down, prescriptive approach allow flexibility for local planning and creativity in partnership with consumers to meet the unique needs of the clients we serve?

Definition, defining long-term care: As a very diverse group of agencies providing a whole range of services to the residents of York region, we would urge the government to define "long-term care." As well, it is imperative that government state what population will be served by the long-term care system. In reading the legislation, we did not find any hint of what long-term care is, nor the population that is intended to receive services. Furthermore, there is an absence of a vision which would provide a framework for a continuum of care. It is not clear how the various components of the long-term care system, including the acute care, are to work together to provide the client with a coordinated continuum of care.

Treatment versus wellness: We understand that the acute care program presently under the mandate of the

local home care program is to be included in the long-term care system. We raise the issue of competition for dollars that may be developed when acute care client need is compared to chronic care client need, the former requiring nursing service for a surgical wound and the latter requiring friendly visiting or Meals on Wheels: Which would you choose to fund?

The commitment to non-union workers: The proposed model for an MSA involves a merger of existing agencies. The government needs to consider the needs for all employees in terms of fair and equitable opportunity for employment in the MSA. Such protection must be afforded to all staff, regardless of their affiliation with unions. Employees represented by bargaining agents have been afforded protection through the successor rights under the Labour Relations Act. Similar protection must be afforded to non-union workers.

Where is the community empowerment? Our community partners embrace the promise and vision of long-term care redirection in both the health and social services sector. This legislation has lost the spirit of the social services system, which is known for being resourceful through volunteer participation, fund-raising and community development, as well as being adaptable, informal and innovative. What may be gained in consistency has the potential to lose in responsiveness to changing community needs.

Unfortunately, this legislation continues to emphasize artificial program definitions which currently exist in the health system rather than taking a needs-based approach. With the passing of this legislation in its current prescriptive form, we see little opportunity for community participation and initiative. At no other time than now is the resourcefulness and creativity of communities needed more.

Will the service definitions fit the needs of tomorrow's consumers? Part II lists two pages of service definitions for community support services: homemaking services, personal support services and professional services. The MSA is restricted to the provision of these services only, unless special permission is granted by the minister for the provision of other services. The service definitions are later used in part VII to differentiate which programs may have charges for service.

These specific service definitions will assure the development of a rigid, inflexible and hard-to-change service system. What may appear to be a comprehensive list may in fact be a barrier to the introduction of new services or the redefinition of existing services which may be required in response to changing consumer needs. Tasks carried out by different providers in the system may also change as the service philosophy evolves.

Further fragmentation in the future: A second tier of services may develop for those who are not eligible to receive MSA services. Private services for those who are able to pay or for those who are assisted by charity will develop outside of the MSA in situations that cannot be met by the inevitably competing priorities of the MSA. We see, in time, the MSA becoming one service provider in an array of profit and non-profit agencies that have varying access and eligibility criteria, the very problem

that Bill 173 is supposed to resolve.

We feel the legislation need only define services as community support services; home and personal support services, eliminating homemaking; nursing services; occupational therapy services; physiotherapy services; social work services; speech-language pathology; and dietetic services. The term "professional services" is an archaic and hierarchical distinction from the other services defined in the act.

**1050**

**Purchased service limits:** Community Agencies in Partnership believes that a limit of 20% on purchased services should not be prescribed in legislation. It is our position that this limit should be eliminated so that each existing community can determine the mix of service providers and agencies that best meets its individual characteristics and future service needs. Each organization in our group comes with a different point of view on this future direction as we work towards a common vision for York region.

**Care givers:** Particularly family care givers were an integral part of the long-term care reform and should be recognized and supported throughout the legislation. Many were very involved in the long-term care reform groups and discussions held throughout York region and expressed their needs for support and respite care support at every opportunity.

**Care givers** were very articulate about their needs and were a great asset to the reform process. Therefore, we recommend that the MSA board composition, part VI, clause 11(2)(a), include family care givers as well. We also recommend that the purposes of the act ensure that there are sufficient services provided to care givers to enable them to continue to provide care in the home without putting themselves at risk. Previous documents indicated that care giver support services would be provided at no cost, and this is not guaranteed in Bill 173.

**Transportation:** York region is a very large area made up of nine municipalities. Some have an excellent transit system and others have none at all. There are many regulations in effect controlling the crossing of boundaries, making access to services virtually impossible for many consumers, particularly for those in the rural areas. Will legislation guarantee access to the service regardless of transportation issues or limitations?

**Cost analysis:** Has a thorough analysis of the cost of the present system, as opposed to the estimated cost of the delivery of the proposed services in Bill 173, been done?

In conclusion, CAP encourages the Ontario government to enact Bill 173 in order to proceed with long-term care reform. However, we hope that the points raised in this brief will be acknowledged and carefully considered prior to the final reading and that this presentation has not been a lesson in futility.

**Mr Cameron Jackson (Burlington South):** Thank you for your brief. When I read the next page of your brief, I look at all the participating agencies and it's quite an impressive list as a coalition of resources, in effect,

Perhaps if this legislation had not been amended on the fundamental point of the brokerage model, which was the big change, the big surprise for everybody who's been monitoring long-term care legislation, studies and research for the last six and a half years, had that fundamental change not occurred, York region's in an absolutely ideal position to proceed with the brokerage model, given this kind of relationship that you've established.

Would you like to comment on that, because I think that's part of the frustration, that 80% of the entire activities in York region are now going to fall under the civil service and all these agencies are going to be competing, in a sense, for that 20%. It's a simplification but it's a fair reflection of what now is going to happen in York region. I wonder if that is the fundamental concern you have, that without virtually any notice this major 180-degree shift in the direction of long-term care was thrust upon you not too terribly long ago.

**Ms Jackie Catto:** If I may I respond to that, I'm the VON board chair, so we certainly, from the VON perspective, have concerns about that. I guess we do see that in York region, as you've identified, we have a very strong operation going and we do question the validity of changing something that is working reasonably well. Certainly, modifications are necessary; we don't deny that, and improvements are necessary. But we wonder about the merit in destroying, so to speak, something that we feel is working reasonably well. We would certainly recognize that the changes are necessary and we're prepared to make those. We are now trying to make some of those but we are concerned about, as you suggest, a dramatic change in delivery of services.

**Mr Jackson:** I appreciate your underscoring transportation, because York region in many respects is like Halton region, where I come from, where we have a strong urban area with the majority of the population that's spread out in a rural area, centred around hamlets and communities and small towns, but still we have not resolved this whole notion of transportation. York region may not necessarily know the shape and direction, the size and number of MSAs that you're going to have in York region. That is still up in the air at the moment, is it not?

**Ms Sillcox:** Yes, it is. I sit as a chair of the transportation advocacy committee in York region. They came out of a study called Gaps to Options, around the needs for the physically disabled, and so we again have been monitoring. But whether there are 20 MSAs, five MSAs or one, the access is still going to be a problem because of the crossing boundaries plus the rural part of the community, very similar to your area. So we're watching that piece pretty closely.

**Mr Jackson:** Mr Chairman, given that the deputants are from your region and since there is a little bit of time, could I yield some of my remaining time to you so that you could ask one or two questions? I know you'd like to. Feel free to use a bit of my time, if you'd like.

**The Chair:** Mr Jackson, you're always too kind, but as the Chair I would allow a question from a colleague from York region.

**Mr Larry O'Connor (Durham-York):** I appreciate

the opportunity. Usually, we only have an opportunity for one caucus to make a remark. I guess the concern that you raised about the rural part of York region is the concern that I've got the greatest, considering my riding is pretty well all rural and contains parts of York and Durham region.

In fact, recently it was brought to my attention that somebody was requiring some home support services from York region and there was delay in getting those services to that client, and in fact a delay in referral to other, different agencies in the community that could have provided those services. The family physician in this case didn't even know about the hospice and what the hospice does. So the gaps out there are humongous.

We have physicians out there trying to refer without knowing whom they should be referring to and who would be the most appropriate people to be phoning. The gaps are large; the services that are available are improving all the time and we're seeing more services. I was quite pleased that we did get a hospice up and running in Georgina recently and I think that it's remarkable. Unfortunately, there are providers in our community that don't know about it.

I know that the district health council will be expecting representations from a number of organizations hoping to be able to perform the services of an MSA and I wondered, if you're going to make a presentation to the district health council, how you're going to reflect the needs in some of those rural communities that are definitely being underserved today.

**Ms Deborah Egan:** I think what we've agreed as a group I can say is that we are looking to participate in the district health council's planning process so that we can bring our concerns and ideas forward through that process, and don't see ourselves doing something outside of that. We're looking forward to being part of that.

**Ms Susan Taylor:** As well, I think that this CAP organization being a group of all of the service providers, and most of the service providers in York region, is an indication that the brokerage model has merit. I'm with the regional municipality and that's certainly our position and that's what we've brought to you before, trying to say that there is an array of service providers out there.

We do recognize that there are some holes and some places where there needs to be better coordination, but this CAP group is evidence that the communities are actually working to do that, and we find this legislation very prescriptive and somewhat interfering in that community development process that is already ongoing.

1100

**The Chair:** Let me simply note that certainly, since the inception of the organization and bringing together everyone in York region, I think we all have seen that as a tremendously positive step, especially in an area that is so widespread and has urban, rural and a whole series of different communities. So, whatever the future holds, I'm sure that you will all continue to play a very important role in the provision of long-term care. We thank you for coming before the committee today.

**Mrs Sullivan:** I'm wondering if I could ask the

ministry to prepare an additional briefing note for the committee.

I was interested in hearing the discussion about transportation that CAP raised and I note that in our material today we've received a brief from the Ontario Motor Coach Association with respect to the provisions included in the bill regarding transportation and the exemption from the licensing requirements of the Public Vehicles Act.

On page 3 of the brief, the OMCA has recommended that the compendium be changed so that provisions in the act only apply to those entities which own or have a long-term lease for a vehicle. I think we should review this issue and I'd like to know if the ministry would prepare a brief indicating what the implications of that recommendation would be. I understand that it would only apply to the agency and not to volunteers, but I think we should know a little bit more about it.

#### ONTARIO NURSES' ASSOCIATION

**The Chair:** I call on the representatives from the Ontario Nurses' Association. Welcome to the committee.

**Ms Jane Cornelius:** My name is Jane Cornelius. I'm the vice-president of the Ontario Nurses' Association. With me are Seppo Nousiainen, who is a research officer with the association; Carol Helmstadter, one of our government relations officers; and Noelle Andrews, the director of government relations, research and arbitration.

As vice-president of the Ontario Nurses' Association, I speak on behalf of 50,000 unionized staff nurses working in the province's hospitals, nursing homes, homes for the aged, community health units, developmental centres and industry. ONA is pleased to have this opportunity to comment on Bill 173, the Long-Term Care Act.

We applaud the government's efforts to provide more alternatives to institutional care. We believe this will pave the way for easier access and more consistency and coordination of services. We also fully endorse the goals of the act, and from our nursing perspective particularly support the emphasis on the needs and preferences of the individual client.

We do, however, feel there are two major areas that are not adequately covered by the bill: first, the issue of human resources for the new multiservice agencies, and second, governance and accountability.

In the area of human resources, we are pleased to see that the act facilitates the use of allied health care professionals. It empowers trained MSA staff to make decisions regarding referrals or authorizations for home health services, while MSA referrals can be made by consumers, family members and other service providers as well as physicians.

We are also pleased to see that the act does not specify which health care professional or worker is to be employed for specific purposes. Rather, the scope of practice as defined by the Regulated Health Professions Act will determine when a regulated health professional will be required. We believe this is a major step forward in providing a more flexible and responsive health care system. However, the ministry must consider and include

more comprehensive human resource planning. Staff at community health agencies have tended to be less costly than institutional staff because these agencies tend to use a higher proportion of less-qualified workers and have a much lower rate of unionization. Agencies may choose to continue to control costs in this manner because of the RHPA exemptions for personal support workers, who perform "activities of daily living" for their clients, as well as the provision to allow regulated health professionals to delegate dangerous controlled acts to lay people.

This policy, which can result in short-term savings, however is very destructive in the long run. The risk of errors and failure to recognize warning signs of deterioration in health status are greatly increased when those without a broad background in health are delivering the care.

Equally important is the risk of failure to recognize other needs in our growing population of frail, vulnerable clients who are coping with multiple chronic illnesses and who frequently cannot advocate for themselves. Inadequate assessment will place such clients at high risk because of delays in treatment, errors in service planning, inadequate knowledge of service options and therefore poorer outcomes when treatment is finally given. As well, treatment is likely to be far more drastic and unpleasant for the client and far more expensive for the health care system when a client's health status is allowed to reach crisis proportions.

We would also point out that the new legislation does not enable our members, registered nurses, to perform up to their level of education. Every public policy document we read says nurses are undervalued and underused. We cannot agree more and point out the inconsistency in using lower-cost untrained workers while refusing to allow skilled, extensively educated and experienced workers such as nurses to perform to the level of their competency.

Most recently, the Ministry of Health has refused to authorize nurses to draw blood and start intravenous lines independently, two procedures nurses perform daily. This is hardly the way to develop a more cost-effective and responsive long-term care system.

The community system currently has available many highly skilled and experienced workers. In Ontario, there are about 1,700 home care case managers, almost all registered nurses, who have over the past 25 years developed a high level of skill in broad-based, holistic assessment and coordination of services, precisely the function of the MSA. In the Kitchener-Waterloo area, for example, home care case managers use over 1,000 community support systems and programs, exactly the services the MSAs wish to use more fully.

We cannot stress enough that many service providers do not have the interest or mandate to link and coordinate health services in a cost-effective way, while those providers who lack a health care education simply do not have the expertise. We strongly recommend the government make use of the service providers like home care case managers who have the education, experience and expertise to carry out the mandate of the MSA, rather

than search for a less expensive equivalent which does not in fact exist.

Nurses are experts in preventive care. As just one example, we would point out the work of the liaison nurses on quick response teams. These teams assess individuals in hospital emergency wards who are over the age of 60. Depending on the assessment results, the nurses may counsel the senior on appropriate health services, discharge them with a referral for home care services or admit them to hospital. In its first year, the Ministry of Health says the Windsor program has saved almost 5,000 hospital stays and close to \$2.5 million in hospital costs at a cost of \$413,000 for home care. Community health nurses do this kind of work in the community all the time. This is indeed cost-effective health care which both saves the taxpayer money and gives the consumer the kind of service he needs and wants. But it demands professional expertise and experience.

#### 1110

We note that the act provides regulation powers to develop and implement recruiting and using volunteers. We suggest this not only be a mandatory requirement for MSAs but included in the act itself. While we have an enormous appreciation for the very valuable contribution volunteers make to our long-term care system, the legislation must make it clear that volunteers should not be used as a cost-saving vehicle by replacing paid service provider hours.

In our experience, clients have suffered at agencies where volunteers were used in place of paid professionals, because volunteers lack the necessary skills. There is also a concern about their reliability and high rate of turnover, which may inhibit the continuity of care.

To our greatest consternation, we have heard DHC committee members suggest that there should either be a salary freeze or that unorganized workers should not be allowed to join a union at the new MSA. This is illegal. As well, there are many poorly managed agencies within the system that operate with a high overhead cost, a deteriorating corporate culture and poor staff morale. Poor wages and working conditions have led to an average staff turnover rate of 80% at some of these agencies. Again, it is not hard to imagine a resulting lack of continuity of care.

We recommend that the act require that each MSA develop a carefully thought out human resources strategy identifying its personnel needs and the level of training required. The requirement must be specific and incorporated into the act itself. Such provision allows those workers who move to a different setting to broaden their array of skills. As well, long-term planning and a collaborative relationship with staff will enable agencies to restructure without painful layoffs and the loss of skills which have taken years to develop.

In the interest of good client service, the legislation must make the assumption that the rights and job security of the MSA staff are a key to high-quality services. Not only should the clients be treated with respect, but the service providers as well. Their bargaining rights must be acknowledged or the clients will be the overall losers.

Experienced people who work directly with clients are the most valuable part of our health and social service systems and represent huge sums of money in terms of education and experience. The new MSA design must reflect this and make effective service delivery its primary goal.

We also have a concern that the act does not make any direct provision for bargaining unit successor rights and strongly feel this point must be spelled out in detail. Successor rights are the continuing rights of employees to be represented by their union and governed by the collective agreement containing their terms and conditions of employment. This is a major consideration with the proposed amalgamation of many agencies under one multiservice organization. The bargaining rights of unionized workers were entrenched in the Labour Relations Act which was amended on January 1, 1993, under section 64, to incorporate a provision regarding successor rights.

With respect to governance, the act itself must spell out clearly how MSA board members are to be chosen and must specifically require the inclusion of front-line providers. It is imperative that adequate union representation be included on the MSA board to ensure that legislative obligations related to successor rights and other rights under the Labour Relations Act are met and that any plan is smoothly implemented.

It has been our experience, particularly with the operation of the hospital fiscal advisory committees, that even when union representation is provided for, effective representation is thwarted by various means. Effective and responsible participation by front-line staff and their representatives will only improve and streamline the process of implementing the MSAs.

We note that the act requires governance at both the DHC and the MSA board levels to reflect the diversity of the population in the DHC's geographic area, including gender, age, disability, place of residence, cultural, ethnic, linguistic and spiritual characteristics of the population it serves. However, the subsection describing the persons experienced in health and social services who are to be included on the board does not specify in any way how these individuals are to be chosen.

For example, the Metro Toronto DHC proposal states that the MSA's governing board will be elected by the voting members of the organization. Without more specific guidance from the legislation with respect to governing the MSA, we feel it is unclear just who will be the members of the board.

We strongly recommend that the act specify what criteria must be met with respect to board participants. We believe they must reflect the diversity of persons working at the MSA and a balance of local interests and perspectives, as well as a mix of expertise, knowledge and experience. All criteria are currently being used for determining the boards of DHCs and their councils and committees.

Despite the DHCs' stated criteria for membership on councils and committees, existing DHCs have been reticent to include labour representatives, claiming they represent a narrow interest of specific organizations or

designated communities rather than a broad overall view. This claim is mistaken. Without a labour component, one of the most important elements of the community is unrepresented. Labour is no more biased or self-seeking than representatives of ethnocultural groups, management, boards of trustees or any other constituency.

As well, labour representatives are the only people who have direct contact with the very people the MSA is designed to serve. If the board is to be well informed as to the realities of client care, since the board should be representative of the community, then MSA staff, including direct service providers, must be included.

Accountability should also be of paramount concern and a primary assumption of the health care reform. However, neither the word "accountability" nor the concept appears in part I of the act, outlining the act's purpose. A commitment to accountability must be included.

We are pleased, as always, to contribute our perspective to the government consultations. If we can be of any further help or if you would like more detailed information on our comments, we would be happy to provide it.

**Ms Carter:** Thank you for an excellent contribution to our hearings. You raised the question of the composition of the MSA's governing board and I just wondered whether we could get a description of just exactly where we're at with that, who is going to be represented, just to make sure that we know what we're talking about here. Could the parliamentary assistant perhaps request that?

**Mr Wessenger:** The composition of the governing board?

**Ms Carter:** And how it's chosen.

**Mr Wessenger:** Yes, how it will be chosen. I'll ask Mr Quirt to indicate, perhaps specifically. There are general provisions, as you know, in the act reflecting the diversity of the community. It will be a board that is chosen by its members. There will be certain criteria set down. One of the criteria, of course, will be a minimum of one third consumer, and I understand that's being looked at.

**Ms Carter:** Consumers and providers must be represented.

**Mr Wessenger:** Yes, and also part of the criteria is that there be representation both of the health providers and the social service providers. Mr Quirt perhaps could add something to that.

1120

**Mr Quirt:** There's not too much more that I can add, other than the MSA has to be a not-for-profit corporation. Generally, our transfer payment agencies are not-for-profit corporations, and normally charitable corporations. They have a membership at the local community level and there's an annual meeting held of the organization. A slate of officers is proposed by a nominating committee, and nominations made from the floor of other interested people, and an election process that tries to make sure that the board of directors is representative of the community to be served.

As Mr Wessenger has pointed out, it's the government's policy position at this point that a third of the

members elected be consumers of the service, whether direct consumers or family care givers who consume respite services or other support services. Your point is specifically whether in fact the government should stipulate whether workers should be included, and I think your point is made very clearly in your presentation.

**Ms Carter:** Sometimes presenters to this committee seem to make the assumption that things are perfect as they are and that therefore, if we backslide from perfection, we're not going forward, as it were. I was interested in your page 7 where you point out that there are some agencies in existence that are poorly managed, have high overhead costs, a deteriorating corporate culture, poor staff morale and very high turnover rates.

The Price Waterhouse report of course has said that by having MSAs there will be a very large saving in administrative costs. It has been suggested to us that this is not the case, that because such agencies as Meals on Wheels rely very heavily on volunteers they are operating as cheaply as is possible. I accept, in that case and others, that we're getting good value at present, but I just wondered if you had anything further to say about the mix of agencies that we have at the moment and the kind of improvements and savings that we're looking at there.

**Ms Carol Helmstadter:** We certainly don't feel that we have a system which is perfect at the moment. But I think the comment that we were making is that we don't want to lose any of the volunteers. We think that's a very important part, a very essential part of community service. But we also don't want to lose any of the expertise among the professional workers. Of course, being a representative of nurses we're talking specifically about our members, the home care workers who seem to be exactly what the MSA is about: people with both an in-depth knowledge of their individual clients and also an in-depth knowledge of community services and support groups.

I think that was the point that we wanted to make, that it would be easy to say: "Let's move to a lower-cost worker. That's a way of saving money." But in the end, we might very well not save money if we have people who are not trained to recognize all the problems.

**Ms Carter:** It is crucial that the people who go into somebody's home, whatever category they're supposed to come under, should have the personal qualities and the training that they need to do that properly.

One question that came to my mind, listening to your presentation: What limitations are there on what volunteers can do? For example, I know somebody who was a qualified nurse, was out of it for some years, went back and ended up working in the operating theatre as a volunteer, because after all she was a nurse. I'm just wondering what the guidelines are that control that kind of thing.

**Ms Helmstadter:** The new Regulated Health Professions Act makes a radical change to what volunteers can do. They can do anything that is not one of the 13 controlled dangerous acts.

**The Chair:** Thank you. I'm sorry that we don't have more time for questions, but I would like to note as well

that in addition to the presentation you also have provided us with another handout that the members have as well.

CAROL KUSHNER

MICHAEL RACHLIS

**The Chair:** I call on our next presenters, Dr Michael Rachlis and Ms Carol Kushner, if they would come forward. Welcome to the committee.

**Ms Carol Kushner:** By way of introduction for those of you who may not know, my name is Carol Kushner. This is Michael Rachlis, who is on the faculty at McMaster University and who works as a part-time physician at Hassle Free Clinic. We've written a few books on health care together. I'm going to turn the podium over to Michael to begin our presentation today.

**Dr Michael Rachlis:** Thank you very much for allowing us to present to you this morning. We have a present for you, members of the committee. If I can give these to the clerk, we have three copies of our new book, *Strong Medicine*, which we would modestly suggest may have something to do with your deliberations on this act. We'll present them to the clerk. There's one for each of the parties represented on the committee.

We first want to make the point that we're in general support of Bill 173, and we would urge you to recommend its passage. However, we would like to explain our support and make a few comments on matters which we think should be kept in mind during the bill's implementation and watching it over the next few years. In fact, we note that many of the key features of the actual legislation remain to be defined with regulations, and therefore we would like the committee to consider some specific regulations.

First of all, we would like to outline our vision for long-term care because I think that reform of long-term care has always included a vision in this province, over the last decade as several governments have grappled with this. But unfortunately I think it may be fair to say that reform of long-term care has been deflected because of the rather narrow views of special interest groups representing different actors in the health care system. This committee of course is hearing mainly, as I look at who's presenting to you, from what I would call special interests within the system, which I would not include necessarily as consumers but people who work within the system who are very concerned about the way the system will operate once the legislation is through.

I just want to remind people of what a vision for long-term care might look like by describing our favourite model of long-term care, which is the On Lok Senior Health Services in San Francisco. We feel that many people who supported the concept of MSAs had this vision of the On Lok Senior Health Services specifically in their minds, so I just want to describe it again to you and explain why I think we should be pointing towards this program.

On Lok was founded over 20 years ago by Mary Lou Ansak, a social worker. The program operates as a not-for-profit corporation. The full name of the program is On Lok Geui—pardon my pronunciation—which in

Cantonese means "abode of peace and happiness." The name reflects the philosophy of the program and the fact that about three quarters of the clients are of Chinese ethnic origin.

People enter the program if they live within a certain area of San Francisco and have been assessed by a California state assessor as being at a nursing-home level of need. At that point, they can either chose to enter a nursing home, in which case the state of California will pay the full cost of their care, or they can chose to enter On Lok. If they enter On Lok, the state pays the program 95% of what they would have paid the nursing home. Altogether, with state and federal moneys, in 1991 On Lok received about \$2,500 US per month for each client, which is not too different from what a semiprivate or private client in an Ontario nursing home would pay, all told, out of their co-pays and public payment.

From this sum, On Lok pays not only for long-term care but for all health care that their clients need, including hospital care, medical care, diagnostic tests and medications, as well as institutional care. The program is at full financial risk for any care their clients need. If their clients get sick and need hospitalization or need surgery, they have to pay for all costs that their clients entail.

On Lok's clients have very high needs: 75% have some incontinence, over 60% have some mental disturbance and 40% are so poor that they qualify for a poverty supplement to their US social security payments. So they are very much a difficult group to care for.

On Lok's funding is not attached to their services. Rather, it is an example of the type of program that many people in health policy these days support, where the so-called funding follows the clients. It isn't that the clients have to follow the funding to get their services; the funding follows the clients where they go. On Lok has complete flexibility in the use of this pooled funding. They don't have to spend their money on institutional services, and by and large they don't.

Most of the services that On Lok's 325 clients receive are from one of their three day-services facilities. At the facilities, the clients come at least once a week, and most come three or four times a week. They get hard services, professional services like medical services, nursing services, dental services etc, but On Lok's focus is on keeping their clients healthy by ensuring that they have adequate nutrition, exercise and social support—what we all need to remain healthy.

I just want to add that the focus of community services in Ontario mainly has been on delivering services in people's homes, which is necessary at some points; On Lok does do that as well. But on the other hand, when I used to watch that commercial for the Ontario lotteries where a woman brought a meal into this old fellow's home, it was his birthday, and she just stayed for a minute, I used to cry, feeling that this was the focus of our delivery of care to seniors, that on someone's birthday they would only see another person for a minute and that person would be somebody who was paid to provide care to them or maybe volunteering to provide care, but not their family, not their friends. The fact that this could

be used as an example of the kind of program that our tax money should be supporting I found to be tremendously sad.

#### 1130

So you can't stay heathy like that, and you won't eat right if you're at home having a meal delivered to you. Mealtimes are social times for us, and that's why many seniors don't eat so well; they get their meal delivered by a very hardworking volunteer and it sits there and goes bad because they don't have anybody to share it with.

At the day centres, the staff pay special attention to the clients' diets. Each client has a graded exercise program. I visited the program twice; Carol's been there once. This is a very frail group of elderly people, but they glow with health. You can be frail and healthy at the same time, and these people's skins glow, their eyes glow. Some people might say, "That's just California; it must be a cult," but they look really healthy. I'm convinced it's because they eat well, they exercise and they see their friends and their neighbours.

The staff do almost anything to keep people out of institutions because On Lok is at full financial risk for their health care. The staff so carefully monitor their clients' chronic conditions that they are virtually never admitted to hospital for the deterioration of a previously identified illness. This is something, in fact, that has been shown in other health services literature, primary care research, that if people have diabetes, heart disease etc, if you're on top of their conditions they should virtually never be admitted to hospital for deterioration of those previously identified illnesses.

The results of the On Lok approach are spectacular. Because of the program's focus on community and home care, On Lok's clients' rates of hospitalization are approximately the same rate of hospital utilization as for the general population of Ontario, probably anywhere from a fifth to a tenth the rate for comparable long-term care clients in Ontario. Although the clients must be rated at a nursing-home level of need to be eligible for the program—they all have to be at a nursing-home level of need to get in—on any given day only 5% of the daily census are actually in nursing homes; 94% are living independently in their own homes.

A breakdown of the On Lok budget, which we've provided on page 2 of our presentation, compared to the Ministry of Health in Ontario, for the 1990-91 fiscal year shows that On Lok has managed to turn the traditional funding pyramid on its head. They've been able to put over half of all their resources into community and day programming, compared to only 16% for institutions and 11% for physicians' care.

I just want to briefly highlight the key points that we think bear on On Lok that we should be remembering as a vision for this legislation and beyond.

First of all, the care provided is based on patients' and families' informed choices.

Secondly, the services are delivered by multidisciplinary teams which are not hierarchical. Traditional health teams are sort of last vestiges of the military approach to organization. Outside of the military, it's only in health

care where you hear about somebody giving somebody else orders. As much as possible, the team member at On Lok delivering any specific service is determined by objective evidence of cost-effectiveness.

Third, the doctors' working groups in here have clear collective responsibility for their tasks, something we'll mention briefly later, that we're quite concerned about the lack of integration of physicians into the service model. Services that promote health and prevent disease, including self-health and mutual aid, have a very high priority.

Finally, the various levels in the delivery system—primary care, secondary care, tertiary care and community services—are all integrated in their financing. It's wonderful to talk about how different organizations try to cooperate with each other. The best way to ensure cooperation is to give them the same budget, and then the dollars are attached to persons, not services.

I'll close my part of the presentation and turn it over to Carol now.

**Ms Kushner:** I want to talk a little bit about the implications of the On Lok model for Ontario's long-term care reform, because, as we said at the outset, we generally support Bill 173 because we see that it has potential over time to lead to this type of service delivery in this province. However, in order for that to happen, it's very important that this committee and other Ontarians interested in long-term care reform follow the development of the regulations in support of this legislation to make sure:

(1) That multiservice agencies truly have the opportunity to allocate resources according to need;

(2) That MSAs are funded on the basis of individually assessed, needs-based capitation payments;

(3) That other services, such as institutional care, medical care, laboratory services and medications, are eventually included in the funding envelope; and

(4) That different MSAs should be allowed to compete with one another for clients on the basis of quality of care and service.

I'm going to highlight each of these points now in the remainder of my presentation. As for the first point, that multiservice agencies truly have the opportunity to allocate resources according to need, over the past decade government documents have invariably mentioned the need to reallocate resources from institutional care to community-based care and from the treatment of illness to the promotion of health and the prevention of disease, but unfortunately Bill 173 only allows the minimum reallocation of resources within community services and home care budgets.

However, if even these funds are targeted to specific services, as seems to be implied in the way the legislation is drafted, then realizing the On Lok vision will be virtually impossible. We must have a way of being able to distinguish among and between personal care services, home care services, professional services and home support services. Moneys in those envelopes need to be able to flow according to clients' needs, and I'm concerned that perhaps they won't be.

On the second point, that the MSAs are funded on the basis of individually assessed, needs-based capitation payments, the funding of MSAs really should be tied to persons and not to services and not to programs. The best way to accomplish this is by making sure that the initial assessment slots a client into one of a number of categories based on their need for care. Clients of course need to be reassessed periodically in a routine way and also any time their condition changes, and there would have to be some kind of minimum criteria for any services that are received in order to ensure that as much as possible what's delivered goes to those who are most in need. The people with the highest needs should have the greatest claim to the system.

Other services are eventually included in the funding envelope, for example, institutional care, medical care, laboratory services and medication. Other services should be included in the funding envelope as soon as possible. There's not much opportunity, frankly, to reallocate within long-term care, community care and community support services. That's not where the opportunities exist.

It's crucial that these other elements be added in order to ensure effective coordination of services and the efficient use of resources as well. In particular, immediate consideration should be given to the addition of the budgets for institutional care, including long-term, chronic and acute care for these patients.

It's been noted repeatedly over the past decade that Ontario's seniors are being dangerously and expensively overmedicated. MSAs would have a strong financial incentive to encourage better prescribing and to reallocate the drug budget to health promotion and prevention of disease and to encourage community care if the Ontario drug benefit plan payment were added to the capitation sum.

Finally, what we think is the most exciting point in all of this is the idea that different MSAs should be allowed to compete with one another for clients on the basis of quality of care and service. We have some concerns that in an absence of competition among MSAs, we might be stifling innovation instead of promoting it.

To avoid this, we recommend that the regulations allow different MSAs in the same geographical area to compete with one another. We suggest that the province routinely publish outcome information about the performance of all MSAs. This would allow perspective clients and their families to make good choices about where to receive their care. One might imagine, for example, that certain MSAs might specialize in providing care to certain types of patients, and information of that nature would be very helpful to clients making such a choice.

Because the funding for the MSAs would be based on needs-based capitation, the total budget for an individual MSA would depend upon the number of clients they attracted and the sum of the clients' individual needs and costs for care. However, for the region, the budget for all MSAs would be fixed, and that's an important point in terms of your desire to have some fiscal responsibility built into the system.

I think these points also speak to the issue of accountability, that when you are monitoring the perform-

ance of MSAs and publishing results about their performance and making those results publicly available, you are in fact creating a climate in which MSAs are going to be very careful about the quality of care and quality of service they provide, knowing that hard measures are going to be documented and published.

Those MSAs which were user-friendly and which provided high quality care within their capitation budget would flourish; those that provided poor quality, unresponsive care would not. We feel that this quasi-market within a public system, with minimal copayments, would lead to improved efficiency and consumer choice.

**1140**

About 0.5% to 1% of the Ontario population requires intensive long-term care. Therefore, a community with 10,000 persons would have somewhere between 50 and 100 people needing this type of care, the kind of care that's delivered by On Lok. This would provide enough clients to create the economies of scale to start up an On Lok-type model of care.

There would be room for some competition in almost all areas of Ontario, and in southern Ontario most residents could choose from 10 or more options. In northern and remote areas of the province, there would likely only be room for one MSA. While that's unfortunate, I think it's important to remember that economies of scale make that option unrealizable.

Conclusion: Bill 173 is a long overdue reform of Ontario's system of community long-term care. We urge the committee to recommend passage and in addition ask the committee to recommend the regulations that we have outlined. These would allow Ontario residents more choice for more efficient and responsive services. Thank you for listening to our presentation. We are glad to take questions.

**Mrs Sullivan:** I think your presentation is a very interesting one. I'm quite interested in the capitative model; I think it's an interesting approach. I like, frankly, what's happened in certain of the HSOs in Ontario, although the rules got a little bit out of whack there.

There are a couple of specific questions that I'd like to ask. When you speak about the potential for MSAs to compete, and to basically compete on the basis of their record of quality of service and quality of care, I'd like to know where you see the evaluative mechanisms coming from and whether the evaluations would change if an MSA was varied, say, by condition or by culture, which are not included in this bill, and I would like to see them added to the geography.

Where do you see those evaluative mechanisms fitting? Who would do the evaluation? Where does the client fit? Could you just speak to that for a minute.

**Dr Rachlis:** We feel that this goes generally to reform of health care. Across the country, as you might know, other provinces are moving to regional systems. In fact, it's only Ontario and Manitoba that have not moved to regionalize their health care systems. Looking at ways in which the province can direct regions, we feel that we don't like the approach in most provinces, where the province is saying, "You need a certain number of beds

or providers per 1,000 people." We'd much rather have the province focus on outcome. So we recommend that there needs to be the development of a whole series of evaluative items which one could refer to as health care performance indicators.

In this case, what I'd be thinking of is using mainly routinely collected administrative data to evaluate the performance of the MSAs, looking at things such as if diabetes is such a common condition among the elderly, what proportion of diabetics get admitted to hospital from an MSA over the course of a year because of deterioration of their diabetes. As mentioned with the On Lok program, if you have someone who's been previously identified with diabetes, if you're providing good primary care, first-contact services, good community-based services, then you should be able to reduce the admission rate of diabetics to almost zero for deterioration of their diabetes.

There's a whole range of indicators like that which would have to be adjusted for the case mix that you're dealing with. Dealing with a population where you've got more widows than widowers, you're going to need more formal services because you've got less informal care that's going on.

I should mention that this whole area is one that is of great interest in the health services research community these days. In the United States there was a consortium formed of health maintenance organizations, or HMOs, in the late 1980s to look at developing quality-of-care indicators.

The consortium has for-profit and not-for-profit HMOs, and of course in the American context they're very much focused on marketing. Some HMOs are now developing report cards where they're outlining their performance according to various quality indicators.

We think, however, that this movement, which in the US has a different beginning, could be very useful for Canada in trying to evaluate the performance of different not-for-profit models like MSAs or the performance of regions within regionalized health care systems. It's not something that I could give you a treatise on right now—"Implement this right away"—but on the other hand, it wouldn't be difficult to start bringing together some indicators that could easily measure the quality of care that would be delivered by MSAs in the next year or two. Because of the tremendous interest in research in this area, there are going to be some very formal systems of assessing quality that will be brought in soon. As I mentioned, there are some US HMOs, starting two years ago, that are actually issuing report cards for the quality of care they're delivering.

**Ms Kushner:** Could I just add one thing? I think it might relate to a second part of your question, which was, if I understood correctly, dealing with the idea that perhaps some MSAs will be targeting certain clientele, certain specific clientele, perhaps an ethnic group, perhaps a group with a specific disease. But in addition to the quality-of-outcome indicators work, one could also look at the quality-of-service aspects, which would come from direct feedback from clients of this service, so that one could in fact have some kind of measure of how well

the recipients of service appreciated those aspects of service: timeliness, friendliness etc.

**Mrs Sullivan:** Do you find it surprising that given that affordability issues are very much on the plate in health care and that quality of care is very much on the plate in health care—the outcomes movement, it seems to me, is a very strong one—that the government has not moved forward on either a pilot or a demonstration project with respect to this entire area of long-term care reform?

**Dr Rachlis:** No, because no other government in the country is doing it. It really doesn't matter what you look at. For example, Saskatchewan was first out of the gate probably this round in making some health reforms, but BC, Alberta and Nova Scotia, with three different parties in power, all are taking very similar approaches and are ignoring some of these key issues.

**Mrs Sullivan:** But how do we know that they're right? Maybe we should test it first.

**Dr Rachlis:** We don't know whether they're right, but I think that this government's approach to not bringing in the things that you've just mentioned is consistent with what's going on across the country.

**Ms Kushner:** In fact, even outside the country. When Great Britain introduced its health care reforms, they didn't want to evaluate them either.

**Mrs Sullivan:** No, but they certainly did have cost measures, though, analysed in advance of setting up their changes.

**Ms Kushner:** They did. I thought we were talking about quality and outcome measures.

**Mrs Sullivan:** Both, because affordability is also an issue. I think there have been an awful lot of promises made without any guarantee of service.

**Dr Rachlis:** If I could, one of the approaches to health care reform that we're quite concerned about is the fact that there's a closure of institutions, there's a cutback in institutional care, which of course is covered by the Canada Health Act, and there's a move to provide more services in the community which are not covered by the Canada Health Act.

So there is an implicit move to privatization when you downsize institutions and develop community-based care, if you don't make explicit that you want this to be within the public budget.

It doesn't matter to me whether I have to pay out of my left pocket in taxes to support my parents in long-term care or out of my right pocket to pay privately; it's still all my money. Any affordability assessment I think has to look at total cost, and that's something that does concern us.

1150

**The Chair:** I regret that because of our agenda that we're going to have to close, but I want to thank you as well for the three books that you left with each of the caucuses. I don't know whether I should say that every member of the committee will have read every single page before we get to clause-by-clause, but I know that the book will be very helpful as we continue our work.

#### VICTORIAN ORDER OF NURSES, BRANT-NORFOLK-HALDIMAND BRANCH

**The Chair:** I ask our final presenter for the morning to come forward, the VON from Brant-Norfolk-Haldimand. Welcome to the committee.

**Mr Don Townsend:** My name's Don Townsend. I'm the new president of the VON branch in Brant-Norfolk-Haldimand, and this is our executive director, Cathy Chisholm.

The Brant-Norfolk-Haldimand branch of the VON is pleased to be given the opportunity to participate in the process that will produce more efficient access to health and social services for the people of Ontario. The local branch has been serving the citizens of Brant county since 1907 and those of the regional municipality of Haldimand-Norfolk since 1970. During this time, VON services have evolved in response to the needs of the communities. VON has been a leader of change in community health across the country and it's from this base of experience that our comments and recommendations on Bill 173 are presented.

It's really difficult to know where to start in the time allotted, but I guess the one thing I wish to convey to this committee from my point of view and from the board's point of view is the feeling of frustration that we are experiencing and that the staff is experiencing because of the tremendous number of unknowns that face us in our decision-making process and therefore by our inability to set a definitive course of action.

I have been a member of the strategic planning committee since its formation. We've worked very diligently to make plans for our future and to increase the levels of quality of service even higher. When it was announced that multiservice agencies would control the delivery of the services we provide in our communities, out of necessity our plans had to change.

We had no doubt that VON would play a major role in the future and that our organization would be a logical sponsor for the MSAs in our area and we worked towards that goal, only to find that sponsorship was not what the government envisioned. We had a glimmer of hope with the suggestion of a federation of service providers and we worked towards that goal of being part of a formal partnership with other local agencies, only to find that federation was also not what the government had in mind.

Under Bill 173, all services will be provided by the MSA itself. We see this as the probable end of our branch, with 99% of our services being taken away. Amalgamation will virtually destroy not-for-profit service providers like the VON. Perhaps the government doesn't feel that these agencies are important and that only the services they provide should be considered. However, there is more to our organization than just the employees and the work they do.

We are concerned that the intangibles that make up organizations like VON are being missed. VON's provincial and national bodies set standards, provide education, innovation, technical assistance and a sense of solidarity and purpose which ultimately directs the activities of each and every employee. The fact is that because of its size

and human resources, VON is able to set and design clinical procedures and standards of practice that have become industry standards. One question why the government would want to eliminate those values that are added to the current system by organizations like VON. We are concerned that those values will be missing from the MSAs of the future.

One of the things that gives the current system its excellence is the continual striving of agencies to maintain a competitive edge. VON constantly strives to be better, not only in proficiency but also in efficiency. Our local VON branch has operated with a strong fiscal management for many years. We have not been a burden to the health care system but rather a valuable asset. Over the past four years the fee per visit for the visiting nursing program has been frozen or has gone down, with the result that increased services were provided to the community. The efficiency of our local branch has become a standard for VON branches in Ontario. We are concerned that the MSA of the future will not retain the same dedication to cost-efficiency which is a direct result of having to maintain a competitive position for home care contracts.

In the event of amalgamation of agencies into an MSA of the future, VON Brant-Norfolk-Haldimand will have to downsize dramatically. We will have to lay off a number of staff. We will have to default on leases. Is the government prepared to offer severance packages to staff and is the government prepared to meet the other financial obligations resulting from the cessation of business? As a non-profit charitable organization, VON does not have the resources to meet such obligations.

As the new president of our board, I am faced with the task of giving direction to the board so that it may in turn provide direction to staff. I want to be able to give them assurance for the future of VON in Brant county and the regional municipality of Haldimand-Norfolk. I'd like to know. Is our government prepared to give me a message of hope for the future of VON to take back to my board?

**Ms Cathy Chisholm:** In particular, VON Brant-Norfolk-Haldimand supports the principles and values underlying Bill 173, and in particular we endorse local planning based on each community's needs, equity of access to services by consumers, one-stop access to a range of services, administrative streamlining, the majority of service delivery by not-for-profit providers, not-for-profit governance and integration of health and social services.

Over the years VON has demonstrated its commitment to the development and implementation of standards of care and the continual improvement in the level of service quality and endorses these as essential components of a reformed health and social service system. As administrator of a large visiting nursing service and an even larger visiting homemaking program, VON Brant-Norfolk-Haldimand is presently completing a reorganization of its structure to create a streamlined administrative process which will support integrated front-line work teams.

Client services will be improved with improved communication between workers who will collaborate on the

development, implementation and evaluation of care plans.

However, our branch does have one specific area of concern. Ontario is a large geographically and culturally diverse province with a complex health care system that includes one of the most advanced long-term community care systems in Canada. The complexity of this environment requires that the service delivery system reflect the needs of the communities it serves. Therefore, one would assume that the proposed legislation would be flexible enough to accommodate the diversity of the population and its communities.

VON Brant-Norfolk-Haldimand is concerned with the apparent lack of flexibility in the legislation regarding the multiservice agency in that only one model for the MSA is acceptable, the one that amalgamates all current service providers into one agency. We are concerned about the potential disruption or discontinuation of services to clients that may occur if all providers are employed by the MSA. During the strike of Red Cross homemakers in Brant county in 1993, the home care program contracted with other agencies for the provision of homemaking services to clients. Home care, as a separate establishment, was not in violation of the replacement worker provisions of the Labour Relations Act because it was not the employer of the Red Cross homemakers.

Under a sole-employer MSA, a similar strike could result in no services for clients. The MSA could not contract with external agencies to provide the services normally provided by its own workers, since to do so would put the MSA in the position of hiring replacement workers and therefore in violation of the Labour Relations Act, and that's even assuming that those other agencies would be there to hire staff from.

Since clients generally cannot do without the services they depend on to remain at home, MSA governing boards will want to settle any labour disputes or strikes quickly. This usually means additional cost to the system in terms of employee wages. Ultimately, there may be a decrease in service, since the current informal capping of the home care program budgets across Ontario will be a reality of the future.

For this reason, we believe that the lack of flexibility in MSA models is not in the best interests of communities. From our observations of this hearing process, it is also not what communities want. The challenge that faces all of us—government, communities, individual organizations—is to improve the current system without discarding all that is beneficial.

Our recommendation is that the legislation must be flexible enough to allow for different governing and service delivery models to meet the varied needs of Ontario communities while meeting government's requirements for accountability. Preservation of the service delivery system for clients must be of paramount importance in the process of reforming the system.

To that end, VON Brant-Norfolk-Haldimand branch is working within its communities to improve services. Partnerships with other provider agencies are being explored. At the same time, VON is working to improve its own organizational effectiveness and cost-efficiency.

We are committed to changes in the health care system that will improve services to clients. Please give us the long-term opportunity to be a partner in the reformed system in Ontario.

**Mr Jim Wilson:** Thank you for your presentation on behalf of VON in Brant, Norfolk and Haldimand. We've heard similar concerns from other branches, obviously, of the VON and from VON (Ontario). I guess I just have a simple question for you, because as far as I can tell so far in our experience with this government in the past with respect to committees and their willingness to dramatically change legislation as a result of committee processes, in the past the government hasn't been very willing, so I suspect the government isn't going to budge on things like the 80-20 rule. Therefore, that and a number of other things in the bill which are of vital importance to the government's agenda will result in the VON being wiped off the map.

What did you do, or what are you doing, that's so terribly wrong that the government feels the need to get rid of you?

**Ms Chisholm:** We wish someone would tell us.

**Mr Jim Wilson:** It's that simple, eh? Because, you know, we've all followed reform—I've been critic for a number of years, Mr Jackson's been critic for social services over a number of years—and we too were caught by surprise, as you mentioned in your presentation, with respect to the government not allowing a federated model of any type or not allowing flexibility.

I get a sense from your presentation that if left alone, if simply the government said, "You must create a model in your community that incorporates the principles of this legislation," you would be able to come back in a year or two, or less time, to give the government an option for an MSA-type organization, whether it be federated or otherwise.

**Mr Townsend:** I don't think there's any doubt that we could work with the other agencies in our communities to do that. Everybody knows everybody in our area and we can work together, and now we're being told, "You're not even going to exist and have the opportunity to work together."

**The Chair:** We have had a number of presentations from various VONs across the province. We thank you for coming before the committee this morning.

*The committee recessed from 1202 to 1405.*

**The Acting Chair (Mr Dalton McGuinty):** Good afternoon, ladies and gentlemen. Welcome to the continuing hearings in the matter of Bill 173, An Act respecting Long-Term Care.

CANADIAN CO-OPERATIVE ASSOCIATION,  
ONTARIO REGION

**The Acting Chair:** Our first presenter this afternoon is the Canadian Co-operative Association, Ontario region. Welcome to the committee.

I just want to put you folks as well as other presenters this afternoon on notice that we've been allocated 20 minutes for each presentation. Given that this is such a brief period of time, we'll generally be restricted to asking one question only, assuming that there is time

permitted for that. That is not by any means an expression of lack of interest on the part of committee members. It is just that time does not permit for us to engage you in more than one question or comment.

**Ms Kathy Bardswick:** My name is Kathy Bardswick. I am the chair of the Ontario region council of the Canadian Co-operative Association. I'm an employee of the Co-operators Life Insurance Co and am the vice-president of our Metro region. With me today are Judy Goldie, the manager of the Ontario region of the CCA, and Myrna Barclay, director of corporate services for the national Canadian Co-operative Association office in Ottawa.

The Canadian Co-operative Association is a member-based organization of regional, provincial and national cooperative organizations. In total, these organizations represent over two million members in communities through Ontario, have assets of over \$12 billion and employ over 7,000 residents of Ontario.

The overall mission of CCA is to enhance and support a united, growing and influential cooperative movement in Ontario. To this end, our organization is involved in government relations, youth leadership development, public education and community cooperative economic development.

CCA has a long-standing interest in health care policy. Along with our member community health care cooperative organizations, we promote the cooperative model as a proven way of delivering cost-effective and high-quality community-based health care to Canadians. Our national policy statement on health care is appended to this brief.

CCA continues to endorse the primary objectives of the Canada Health Act. We are committed to the five publicly stated goals of medicare, including administration by public agencies on a not-for-profit basis. We believe that the health care system should be focused on the consumer, on prevention and that it can be much more effective and cost-efficient. Reform must include community-based health care as an integral part of Canada's health care system.

The financial limitations facing all levels of government, coupled with growing health care demands, lend a particular urgency to the need for health care reform. CCA recognizes that Bill 173 brings major reform to the long-term care system, which should be more effective for users and more efficient for taxpayers.

CCA believes that the cooperative model has something to offer the long-term care sector in Ontario as it reorganizes to focus on the users of the service, becomes more efficient and effective and involves the community in governing the system.

Last October, in a statement to the Legislature, the Honourable Floyd Laughren commented that, "We want more people to know about this model, because we are certain many more people will find the cooperative approach suits their goals." The current and previous two governments in Queen's Park have favoured the not-for-profit community-controlled development of community health care centres as a major thrust for reforming the health care system. There are now 53 CHCs in Ontario,

and we urge all members of the Legislature to support the growth of this exciting new component of health reform.

Recently, the Legislature passed amendments to the provincial Co-operative Corporations Act that provide a more flexible framework in which cooperatives can develop. Provisions were added for multistakeholder cooperatives, a cooperative structure which we feel has great potential for both community health care centres and long-term care multiservice agencies.

We support this act's focus on alternatives to institutions, illness prevention, user-friendly service, equitable access, efficient management and community governance. Our comments and recommendations focus on the governance structure of the proposed multiservice agencies. I will begin the discussion with an overview of the multistakeholder cooperative and then point out the advantages which this model has for MSA structure and governance.

Cooperatives are rooted in the mutual self-help tradition. They operate economic, social and service enterprises according to the same principles that underlie political democracy. They are membership-based and governed through the application of democratic principles. Board members are elected and accountable to the constituencies they represent.

Cooperatives can be incorporated as profit or not-for-profit corporate entities. There are many examples of not-for-profit cooperatives without share capital, such as housing co-ops, child care co-ops and health care co-ops. It is this form, that would be appropriate for multiservice agencies.

In the multistakeholder cooperative, each constituency vital to the success of the organization is identified. The stakeholders, either individuals or organizations, become members of the cooperative. The number of seats on the board of directors is then divided up among the identified constituencies to achieve the balance of control desired. Usually, no one group has a majority of board directorships. Each constituency elects its own board representatives from within its membership. Membership meetings with each constituency, held either separately or together, can be used to consult a wider base of participants/stakeholders. All interests are included, with clear lines of accountability.

The cooperative model is already working successfully in community-based health care centres. We refer you to a study prepared by Doug Angus, Community Health and Epidemiology, Queen's University, and Pran Manga, MHA program, University of Ottawa, entitled *Co-op/Consumer Sponsored Health Care Delivery Effectiveness*. This study assessed the efficiency and effectiveness of this type of health care delivery model. The study identifies economic and non-economic advantages of community-participation health care centres and calls for legislative reforms to recognize that such centres are an important delivery model in the health care system. Major advantages over other service delivery models are included in this brief.

The authors summarize by saying: "These advantages make such cooperative or consumer-sponsored health care centres very good vehicles for carrying out many of the

government health system objectives and priorities. Indeed, that is why they have been and continue to be strongly recommended by virtually all the commissions of inquiry over the past two decades."

The Co-operators Data Services Ltd, one of Canada's largest computer service companies, has been operating a multistakeholder cooperative since 1986. Its major stakeholders include the employees, major clients and suppliers of capital.

Control of the cooperative has been divided among these stakeholders, bringing gains in productivity and client-sensitive services. All permanent staff may purchase membership shares. In return, they can run for one of the two staff board of director positions or one of the staff representative positions to the annual meeting. Staff who are members can vote for their representatives and can attend CDSL annual meetings. CDSL believes that the major advantage of the stakeholder model is the "voice option" that provides the means for, and encourages its major stakeholders to be involved in, the enterprise, both in terms of operational improvements and the longer-term direction of the cooperative.

Other advantages include an increased number of perspectives at the board table, which lead to better decision-making, increased staff knowledge of the policies which drive the operational plans and budgets and increased staff focus on the results of the organization.

Stakeholders in the multiservice agency would be the consumer-users of the services, other service agency providers and the employees. The government of Ontario is also a key stakeholder, but it need not have a position on the board. Government will have considerable influence over MSAs through regulatory and fiscal controls.

The cooperative model should receive support from those within the long-term care system who are concerned with strong, explicit lines of accountability and who believe in the long-term benefits of democratic methods applied to institutional governance. The cooperative corporate entity, particularly in its multistakeholder form, is a concrete example of public-community partnership in action. Multistakeholder cooperatives are built on the belief that groups that build and benefit from an agency should be in control of it as decision-makers, rather than just advisers.

There are a number of reasons for considering a stakeholder cooperative as the structure of choice for a multiservice agency:

Greater accountability. The cooperative structure explicitly reinforces control by and accountability to the main groups for whom the multiservice agency exists: the users of the service, other service providers in the community and employees. Public accountability, as represented by the government, is achieved through funding agreements and other government administrative or regulatory directives that the MSAs must follow.

The conscious development of an MSA membership through a cooperative structure creates a community base for the MSA. This will strengthen the board, because members will provide a definite constituency for whom the board is accountable. Strong stakeholder boards will

ensure that MSAs are not management driven or ministry driven but community driven, the intent of this legislation. MSAs would move beyond community participation to community control. We believe that control is necessary if health care consumers are to be truly empowered. I want to reiterate here that "consumer" refers to the actual service user, in addition to representatives from community groups.

The cooperative model incorporates a commitment to education of the membership, the board of directors and the employees. The cooperative sector, in its commitment to education, has produced educational materials on member participation, board management responsibilities and other governance issues. With education and with a defined constituency, community boards can provide directional leadership rather than simply react to managers and funders.

The government of Ontario has been encouraging the broader public sector to achieve efficiencies by working together to improve services and reduce cost. This is the essence of cooperation.

The co-op model is a logical structure to achieve these efficiencies. The cooperative sector in Canada has built its structure and growth around increased efficiencies through economies of scale and the fact that the whole is greater than the sum of its parts. We know we can achieve collectively what is difficult to achieve individually. In fact, the model proposed here would be most efficient if it reflected the intent of amalgamation underlying Bill 173.

Cooperatives reflect and strengthen the democratic tradition in Canada. The application of democratic principles to our health care system is long overdue in Canada and simply an extension of our democratic tradition.

Our recommendations:

(1) We recommend that the government promote the stakeholder cooperative model to communities as they develop their multiservice agencies. The stakeholder cooperative model is well suited to achieve the purposes of the act as stated in part I.

(2) We recommend that the government amend part VII, section 16, of the act to enable employees of the agency to be directors of the agency. As strong community-owned cooperatives, the MSAs could not be viewed as government agencies. The argument against employee directors therefore diminishes greatly. Community health centres across Ontario have already set a precedent with employees on several of their boards. These organizations are funded by government but operate at arm's length with community boards, much like the MSAs are intended to do.

(3) We recommend the government ensure that MSAs have sufficient funding to keep their stakeholder members informed and participating in their organization and the board of directors informed of its roles and responsibilities. Maintaining healthy democratic structures requires work. Education and training dollars are essential to successful and democratic board operations. Community health centres in Ontario recognize the need for enhanced

funding of director education, including diversity training, to improve both community representation and board effectiveness.

(4) Finally, we recommend that the government encourage MSA boards to be of a suitable size for maximum board effectiveness. In our experience, large boards at the local level inhibit maximum group effectiveness. When organizations amalgamate, there is a tendency for the size of the board to be larger than would normally be considered workable.

In summary, we urge the standing committee to consider the stakeholder cooperative structure in designing multiservice agencies. We are willing to provide the committee with more detailed information and would be pleased to work with the government during the MSA implementation phase.

**The Acting Chair:** Thank you very much for your presentation. The parliamentary assistant wishes to ask a question.

**Mr Wessenger:** It's interesting to hear a novel approach with respect to an administrative structure. I have some questions, though, about the stakeholder co-op model. I suppose the first question is, do you feel this model could meet for instance some of the eligibility criteria with respect to representation on the board? How do you see that being effected through a multistakeholder model, for instance, the criteria of consumer representation, the criteria of expertise in the social service and health area, plus perhaps we'll say managerial expertise?

**Ms Judy Goldie:** In the process of creating the stakeholders' model, you have to identify who the stakeholders are and then predetermine what kind of balance you want on that board, taking into account those eligibility criteria.

**Mr Wessenger:** If I could just follow that up. With, say, a normal non-profit corporation model you would have probably a membership that would be open to everybody in the community. With a multistakeholder model it would seem you would have somewhat limited opportunity to participate in the management of the model. I'm just suggesting that might be a problem, that you'd have a much narrower base of representation on your board in a multistakeholder co-op model than you would with an ordinary non-share, non-profit corporation.

**Ms Bardswick:** Just to expand on the answer provided, the pool of resources for the board would come from the user community at large for the MSA, which would be a fairly broad pool to begin with. It could also include, if that's the way it was structured, representation from agencies or other suppliers of services, be they technical providers of services or service delivery providers. Management, of course, is sitting as advisers to the board in any board situation, and any other external provider who is seen as providing or having a major stake in that organization. Given that the model is as flexible as it is, you can provide that kind of balance of expertise on the board.

1420

**Mr Wessenger:** Another question: Can this model be a charitable corporation? Do you know? I think that's

very important, that the model have a charitable status so that it can receive donations that are deductible.

**Ms Bardswick:** Yes, it can.

**Mr Wessinger:** In your opinion, it can.

The other aspect I'd like just to follow up on, you indicate you believe that the governance model should include the opportunity for employee participation on the board as voting members. Is that correct?

**Ms Bardswick:** Yes, it is.

**Mr Wessinger:** Would you agree that there should be consistency among various types of health institutions with respect to this model of governance? If you have employee participation, as you say, on some of the community health centres—some of them have it, some of them don't—on a broad-based approach, do you think all sorts of services, all these comprehensive health service agencies, should have employee representation on their boards?

**Ms Bardswick:** Yes, we do. The fundamental aspect and concept of a multistakeholder organization insists that there be that kind of balance and influence from the major stakeholders of the organization. We believe that in any such model employees are indeed major stakeholders and therefore should be represented on the board.

**Mr Wessinger:** The reason I'm pursuing this particular aspect is, when I did a number of hearings on the Public Hospitals Act, it was often suggested that the representation by employees be voiced without vote. You don't feel that's an effective model, having only the representative voice but no voting rights?

**Ms Bardswick:** In fact, we submitted a brief at that point as well that did recommend that employees do have a voice on the board and we feel it would be—

**Mr Wessinger:** Have a voice?

**Ms Bardswick:** And a vote.

**Mr Wessinger:** And a vote.

**Ms Bardswick:** Yes. We don't believe voice is very effective without vote.

**Mr Wessinger:** Right. Okay, fine.

**The Acting Chair:** Thank you very much for your presentation.

#### TRANS-ACTION COALITION

**The Acting Chair:** Our next presentation will be made on behalf of Trans-Action Coalition. Welcome to the committee.

**Ms Janice Tait:** The summary of recommendations is at the back of the presentation. I'm not going to read my brief because in the body of the brief are some rather technical descriptions of transportation matters. I'm just going to talk to some of the recommendations, the ones that I think are the most important.

First of all, I'll just tell you that the Trans-Action Coalition is a coalition of over 100 member organizations working to improve transportation for people with transportation disabilities in the province. The Hickling report, in 1992, estimated that about 10% of the population is transportation disabled.

Second, I would like to say that although I understand

that the Ministry of Transportation is supposed to be a partner in this exercise, our impression is that it's more of a silent partner than a partner, with the emphasis on silence. As far as I can tell, and I've had 15 years of close study of the MTO, it's doing almost nothing in this area.

So the first recommendation that I want to make to this committee is that the role of the MTO be identified and defined. We believe that the Ministry of Transportation ought to develop a policy setting out its long-term commitment to people with transportation disabilities in Ontario. They have never developed a policy in this area.

We also believe that transportation is not a social service. There is a good deal of disagreement about this across the country, but we are very firmly of the opinion that transportation is a public service, like water, sewage, garbage disposal, and it should be run as a public service. This puts us in direct conflict with a lot of the work that has gone on in the transportation committee, because there's a very strong emphasis there on volunteer transportation services.

I'd just like to give you an example of what happens when you have volunteer services. Pickering has a public transit service. Pickering, I think, is a city of about 40,000 to 50,000 people. It has public transit, it has a specialized transit service and it has a volunteer service that grew out of the home care, home support. But the public specialized service operates from 9 until 6 and it does not cross a municipal boundary.

This crossing of the municipal boundary, have you heard anything about this? Do you know about this?

**Mr O'Connor:** Big problem.

**Ms Tait:** Huge problem. It's a problem that MTO could solve, but it has not chosen to do so because it says it's a municipal responsibility. Well, it's a municipal responsibility and it puts tremendous strain on specialized transportation services.

In Pickering, if you want to travel after 6, on weekends, on holidays or you want to go to Toronto, you use the volunteer service, and if you want public transit from 9 to 6, you use the public specialized transit. But having that volunteer service undermines the public specialized transit and it lets the ministry off the hook on providing a public service.

So there's been a lot of talk in our committee that throughout Ontario these MSAs are looking at volunteer services to fill the gap, and we absolutely disagree with that. We fundamentally believe that is the wrong way to go. It may be necessary in the short term, but it is not sufficient.

We believe that everybody in Ontario has the right to some kind of public transportation service, especially the people who have no cars, which is about 30% of the population. And who are we talking about? The young, the old, the unemployed, the poor.

We feel that there are ways for the ministry to provide transportation to people in small towns and rural areas. We believe that whatever transportation is set up should be available to the people in the area besides those who are in long-term care; that is to say that the public

transportation service should be for everybody, and the people who are in long-term care should buy the service, just like anybody else.

That means that everybody pays a fee. We've spent a lot of time on the subject of fees, but in the area of transportation it seems to me to be very obvious: Everybody pays a fare. Now, the fare is not always the same in every area, but equity demands that within an area people pay the same fare.

More important, we think we have a solution to how to provide transportation services throughout the province on a very cost-effective basis, and it's called a brokerage system. Really, it works the way a taxi company works now, but in our view it should be publicly funded and publicly run. That means the Ministry of Transportation has to provide subsidies to local governments and regional and county governments to set up a computerized dispatch system and scheduling service.

With that computerized dispatch system, you take all the vehicles in every community that are available. You know, we have ambulances that are often not in use; we have school buses that sit idle from 9:30 to 3:30; we have Comsoc vehicles that transport people with cognitive disabilities and then sit idle. Presumably, there sometimes is a certain number of specialized transit vehicles. So there are a lot of vehicles in every community that are not being used effectively. If they were all a part of a brokerage system, we could use those vehicles 24 hours a day, everywhere.

1430

The second thing is that besides all these vehicles that are available and not being used, we have in almost every municipality in Ontario some kind of taxi system or a taxi system that's available within 20 minutes, half an hour's call. Our view is that the taxi system should become a much more active partner in providing transportation services, particularly in the rural and small town and suburb environment. It's quite easy to do this. There are several ways to do it, but one of the most effective is not to subsidize the transportation system or the service providers but to give the users a transportation subsidy in the form of what is called "scrip." That's a book of tickets that entitles you to a trip at a standard transit fare.

In Britain, all people with transportation disabilities are subsidized; they all get a transportation subsidy every month. If we want to have equity in terms of access to the service, then this is a very reasonable way to give them that kind of access. They could phone up a taxi, give their ticket to the taxi driver, and the taxi driver submits the ticket with the balance of the cost of the trip to the local agency for reimbursement.

They're doing this in Vancouver, in Calgary, in Kitchener-Waterloo, and they're just about to start it in Hamilton. What they have found is that an average trip usually costs about \$10 over 80,000 trips over a year, so also it's a very good way to put a cap on the amount of money you spend on transportation because you've got some control through the sale of these books of tickets.

The other thing we absolutely believe is essential is that more accessible cabs be made available throughout

the province, and in order to do that, we believe that MTO must raise the subsidy. An accessible cab costs about \$40,000; \$20,000 for the vehicle and about \$20,000 for the modifications at the moment. MTO offers a \$10,000 subsidy, but it is not enough of an incentive for a small company to purchase an accessible vehicle.

If the subsidy was 50%, that is to say \$20,000, that would match the subsidy MTO now gives for buses and vans. It seems to us to us it would be fair if they offered 50% on the accessible taxis. If we had the use of the vehicles that are in place in the communities, plus a scrip system to access conventional cabs and accessible cabs, we could probably provide transportation for everybody at a reasonable cost. By the way, most trips that are taken in ambulances at \$240 a shot could be taken in an accessible cab at \$15 or \$20.

Those are some of the recommendations that we are making. Most of all, we are hoping very much that you're going to be able to keep the feet of the Ministry of Transportation to the fire.

**Mrs O'Neill:** We haven't had a lot of presentation in this area, although we did have one this morning. I wanted to ask you about a couple of your recommendations, if I might.

**Ms Tait:** Sure.

**Mrs O'Neill:** "Recommendation 5: That eligibility committees must not include representatives affiliated with the transportation service but must be completely independent."

From what you've just been saying, I felt your group and others have had some cooperation with the transportation providers, so I'm wondering, there must be something behind this recommendation.

**Ms Tait:** Yes, there is.

**Mrs O'Neill:** Could you say a little bit about that, please?

**Ms Tait:** Yes. We feel that the eligibility committee that is operating here in Toronto advising Wheel-Trans is a captive of the TTC. The people who were chosen were chosen by the TTC, they report to an advisory committee which was also chosen by the TTC and is run by the TTC and even the people on the committee get their honorariums paid by the TTC, so they never criticize the TTC.

**Mrs O'Neill:** Okay. That's a pretty clear answer.

My other one is in the following recommendation: "The Minister of Transportation make clear to the people of Ontario that prioritizing of trips on specialized transportation services is contrary to the equality provisions of the Charter of Rights and Freedoms...."

**Ms Tait:** And the code.

**Mrs O'Neill:** Could you say a little more about that? I have also a bit of difficulty with your final statement about the ambulances. Surely there can't be that many trips. You seem to indicate that it was the majority—

**Ms Tait:** I think the ambulance people themselves estimate that about 70% of the trips could go by accessible cab.

**Mrs O'Neill:** Is that right? That's much higher than

I had heard, but in any case we'll leave that. Maybe you could say a little about this point.

**Ms Tait:** Yes. On the prioritizing of trips, there was a recent decision—I don't know if you've heard about it, the Roberts decision—from the Human Rights Commission.

**Mrs O'Neill:** I'm sorry, I haven't.

**Ms Tait:** It basically says that if you're offering a special program, you cannot discriminate within that special program. The public transit doesn't prioritize trips. On public transit, everybody can take any trip they like and nobody asks what the purpose of the trip is. We believe the specialized transit should have comparable service. In fact, the new Ontarians with disabilities act is going to recommend just that, that the service should be comparable, and that means no prioritizing of trips.

**Mrs O'Neill:** So it wouldn't be just for medical appointments; it could also be for visiting a family member.

**Ms Tait:** Absolutely, because when it says "community access," you don't define what community access means. You assume that you know, and that means whatever access you want. I had an 80-year-old woman in tears on the phone to me a month or so ago because she had a ticket for Miss Saigon and Wheel-Trans offered her a one-way ride. She could have got to the show, but she could not get home, so she had to give it up.

**Mrs O'Neill:** Thank you for coming, Ms Tait.

**Ms Tait:** That's the way it goes.

#### ONTARIO ASSOCIATION OF RESIDENTS' COUNCILS

**The Acting Chair:** Our next presentation is being made on behalf of the Ontario Association of Residents' Councils. Welcome to the committee.

**Mr Peter Kehoe:** My name is Peter Kehoe and I'm president of the Ontario Association of Residents' Councils. Mary Ellen Glover is the executive director.

We have prepared a brief which I understand has been distributed to you all. Mary Ellen Glover is going to run through the brief with you, and we will both be available to answer questions and, I hope, be able to explain any points that you may wish clarification on.

By way of introduction, our association represents some 300 facilities here in Ontario where they have what they call residents' councils, which are intended to be a voice speaking on behalf of the residents who live in the facilities. They're supposed to express the feelings of the residents towards the executive director and the management of the facility and also to relay to the residents the intention and policy and the management philosophy of the board of directors and the executive director. So it's a two-way method of communication.

We also act as a channel through which the government frequently relays information and asks us to relay to it information regarding the feelings of residents on particular issues.

**Ms Mary Ellen Glover:** As Mr Kehoe said, the Ontario Association of Residents' Councils represents seniors living in long-term care facilities. While many of

our members will not be directly affected by Bill 173, we do have members living in retirement homes and seniors' apartments who could seek the services of a multiple service agency and, indeed, who would be eligible to represent consumers on a board of directors.

#### 1440

We also believe very strongly that all seniors, whether they live in the community or in a facility, are entitled to have their rights recognized and respected, be treated with dignity, compassion and respect and have appropriate information to allow them to be informed consumers.

As an organization, we have participated in discussions on many aspects of reform and have noted with great interest, and some alarm, the problems that appear to be surfacing. Indeed, our organization has in the past attempted to warn the government about some of these problems. With this bill, we wonder if government is biting off more than it can chew. Does it have unrealistic expectations in the following areas: the protection of client rights, client right of choice, funding and the governance of multiservice agencies?

In this bill, clients are given a bill of rights, but will this bill of rights truly provide adequate protection? It refers only to the client's right to "raise concerns" and "recommend changes." What guarantee do we have that a client who does raise concerns will have a problem resolved? Our experience has shown that it's difficult enough to ensure that residents' rights are respected in facilities where there is a system of checks and balances in place. Who, I ask, will protect frail, isolated seniors?

Furthermore, the bill appears to be at variance to itself. On one hand, clients are given a bill of rights to protect them. On the other hand, Bill 173 appears to deny or limit the individual's right to have access to their own records. It appears that a review board will decide whether or not the individual can have access to his or her own records. All this will be done in the absence of the individual. Is this fair? Will the service provider also be absent? Will there be an advocate present? Who is the review board?

In more practical terms, we would strongly recommend that the legislation require that all personal care/home support workers be bonded and insured to protect both themselves and the client. As well, an appropriate system of monitoring such as the compliance inspection system for facilities must be put in place to protect clients and to ensure that the service provided meets the standards that I'm sure will be set. The bill refers to the compliance adviser entering the MSA place of business, but this will not ensure that the service provided in the individual's home is adequate.

We believe in right of choice. The entire bill says to us: "Big Brother knows what is best for you and will tell you what that is. You will receive the services that Big Brother feels you need."

The bill refers repeatedly to "preference" rather than "choice," two words that definitely do not have the same meaning. The use of "preference" leads us to feel that any choice made will not be by the client but by the agency.

For example, will the MSA be sensitive in their assessments of potential clients? Will assessments take emotional and social needs, as well as physical needs, into account? Will cultural and religious traditions be respected? During facility reform we were guaranteed that placement coordinating services would take all these factors into account when placing clients in facilities. Now anecdotal evidence indicates that placement coordinating agencies are not respecting client choice when making facility placements. Why will multiservice agencies be different?

Furthermore, it would appear that the power of the multiservice agency will be all encompassing. What then will happen to a client who is not satisfied with an assigned service provider. Will the only choice available to the client be to remove themselves from the system and make private arrangements for services? For most people, this is simply not a choice because very few would have sufficient financial resources available to pay for a full range of private services.

We further wonder how the MSA will determine who will be eligible to receive services. We have a real fear that services will be withheld or people will be underserved as a means of controlling costs.

That leads to the matter of funding, an area in which we have only questions. Where will the money come from? Who will pay for what and to what level? How much will the client be asked to pay? Will the estimate of the amount potential clients will contribute to the system be realistic? Will the necessary revenue be generated from copayments? What factors will be taken into account when testing for subsidization? We would certainly not like to see consumers in the community and consumers in long-term care facilities subjected to different criteria.

Governance of MSAs: The act states that the board of directors must reflect the diversity of the community in terms of gender, age, disability, place of residence, cultural, linguistic, ethnic and spiritual factors. However, it would appear that, at least initially, MSAs will be set up by what are really special-interest groups. For example, our organization received an invitation to develop a proposal to establish an MSA. Initial boards will therefore probably be made up of people who are already active in one or more specific organizations.

In our opinion, this could lead to a great deal of friction as these boards, at least initially, will be torn by internal power struggles as individual agencies jockey for control. Some controls must be put into place to ensure that the community is truly represented.

We spoke earlier about the fact that residents in retirement homes could be eligible for the services of the MSA. How can a resident obtain membership in the MSA so that he or she would be eligible to stand for election to the board of directors. There must be some mechanism in place to ensure that the community as a whole is educated about becoming involved in the establishment of MSAs.

We also question whether it is realistic to believe that a volunteer board can effectively set up such a complicated agency from scratch. The process will require a

heavy time commitment if board members are required to be hands on and undertake specific tasks. If the board is not expected to do the work, it will mean they will require staff to assist them and each MSA will end up with its own little bureaucracy. Money which could be used to pay for client services will be diverted to support services.

We also wonder whether the qualifications the individual is expected to bring to the board are realistic. Many not-for-profit agencies are saddled with boards made up of individuals with personal, specific agenda who are not willing to work for the common good or the agency is so desperate that it will take the nearest warm body to fill the position.

MSAs will be not-for-profit agencies. Will they also be allowed to become registered charities and, if so, what effect will their fund-raising attempts have on established charitable organizations?

MSAs are to be set up and governed locally. Therefore, we question whether or not this will provide clients in all parts of the province with the same services provided to the same standard. We have two scenarios to put to you: Can you assure us that both these ladies will receive the same services at the same cost, both to them as clients and to us as taxpayers? If so, we can assure you that we are all in favour of the concept of MSAs.

We have two elderly women, Leona and Hazel, of a similar age, 80-something, and similar financial resources. Both live independently in their own homes. Both are faced with a health crisis.

Leona is hospitalized, tests are performed. It is determined that she has anaemia, but the cause is unknown. She is told that she can go home. However, because she has suffered from breathing difficulties, particularly at night, she's afraid to go home alone. She is declared ineligible for home care because she admits she really doesn't need a nurse to help her take a bath. She is also told she doesn't look like a frail old lady and, if she's not happy, perhaps she should enter a retirement home.

Because her family lives in a different city and her support network consists of friends the same age, she feels her only option is to enter a retirement facility for a period of convalescence. The doctor keeps her in the hospital an extra four days until she can find a bed. Meantime, her daughters take turns leaving their families and their jobs to come and stay with her when she leaves the retirement home. They try again to access services for when they must leave her alone. Meals on Wheels is easy. That's no problem, \$5 per day, no charge to the taxpayer. First meal is just yummy—corned beef and cabbage, no choice. That's just great in the middle of the summer, great for a person who is seriously anaemic and really needs to eat properly.

Homemaker services are a different story. Yes, they're available at a cost of \$8 per hour. However, it will be three weeks before the agency can even come to do an assessment. Oh, and by the way, the workers are not insured or bonded so the client had better check with their insurance agent to make sure they have appropriate coverage in case the worker has an accident.

Because Leona requires ongoing monitoring, each week she must make her way to her physician to have blood work done. Transportation, thankfully, was provided by family and friends.

In this scenario, there were minimal services available. The only costs that were borne by the taxpayer were perhaps four unnecessary days of hospitalization while waiting for a retirement home bed, and visits to an MD for something that could have been monitored by a nurse. However, the cost to the individual and her family amounted to approximately \$3,200 in cash outlay and perhaps another \$4,000 in lost wages.

1450

In our second scenario, Hazel, our client, is hospitalized. Her immediate problems are diagnosed and, after a long hospitalization, remedied. However, she has lung problems which must be monitored. When Hazel is feeling better physically, she is assessed for multiple infirmities and rehabilitation begins. When rehab has advanced sufficiently, she visits her home in the company of an occupational therapist to check for possible problems that she might encounter when she returns home and to make sure they are solved prior to that return. She is given the option of going home for one night on a trial-run basis with support. She doesn't take this opportunity because she feels confident in going home on her own.

When Hazel returns home after a hospitalization of approximately four months, she returns with the service of a visiting nurse seven days a week, a personal support/home care worker twice a week and Meals on Wheels purchased frozen from a weekly menu so that she can mix and match and use as she wishes.

Six months later, she still receives the services of a visiting nurse twice a week to assess her lung condition, therefore she does not need to make weekly visits to her physician. Home care now only comes once a week, but for a longer period of time, and she is still enjoying the frozen Meals on Wheels. In this scenario, the cost to the individual is limited to the cost of the meals she purchases. All else has been borne by the taxpayer.

In closing, we have the following recommendations: MSAs must ensure equitable access to equal services; the government must ensure that the goals set out in this bill are realistic and can be met in terms of funding and the establishment of cohesive boards that will work for the good of the community.

We would lastly recommend that before starting anything new, the government finish with facility reform. Get that working and working well before launching any new initiatives. Thank you very much.

**Mr Jim Wilson:** Thank you very much for a very comprehensive and, I think, very commonsense approach to this legislation through your presentation here today.

There's nothing you said that I and I think most of my caucus colleagues would disagree with in my party. In fact, you point out a lot of flaws in the legislation that we've also been bringing to the government's attention from time to time, particularly your comments about the elimination of choice under this legislation, and the eligibility criteria, which is a mystery.

It's an absolute disgrace that we, as legislators on behalf of the public, are being asked to pass such a major piece of health care legislation and we haven't got a clue what the eligibility criteria will be which, as you point out, is absolutely key to this whole system.

In fact, I suspect the underlying agenda here is the eligibility criteria, as we saw in the new long-term care facilities legislation with Bill 101, where a very high medical test was put in place to get into those facilities. The eligibility criteria is really the tap the government has in the future to choke off people, some who may be getting services now. There may be people getting snow removal services, for example, as part of community care now who won't meet whatever the new medical tests are or whatever they're going to be.

We're not clear on what the eligibility criteria will be. We're not clear about user fees—we do know in the first stage of reform \$647 million. What the government forgot to tell the public was that \$150 million of that was to come out of their pockets in terms of the new user fees that are now in the long-term care system. The government even managed to mess that up so badly that it collected significantly less money than it expected because of the means test that they put in, which was simply an income test and not an asset test.

Your very last point is very interesting where you tell the government to sort of get finished with the facility reform, I think is the way you word it. Perhaps you want to just expand on that because there is a real concern with most of the presenters to this committee that the government's closed 7,200 hospital beds since 1989-90 and yet we haven't seen the beefing up of community-based services. In fact, all this bill talks about, I think, is raising expectations that those services will be in place, but it talks more about governance, creating a monopoly and a bureaucracy and not a lot about the delivery of front-line services.

Can you just tell us what you mean specifically by telling the government to finish with facility reform before it keeps up its social experimentation?

**Mr Kehoe:** I'll be glad to volunteer a couple of remarks. We, as an organization, generally speaking, endorse most of what was done in Bill 101. We can nitpick and quibble about details, but in principle I think we could go on record as being in support of most of what was being done.

We feel that the criteria for eligibility were moved forward in the right direction. We have misgivings about funding, but that's still being worked on, I gather. We feel concerned about the long-term security of funding for the facilities and whether it's going to be adequate or not, but I gather that's being reviewed regularly. We're concerned about the quality of care being maintained and the quality of life being maintained, but those are our four principal concerns as far as long-term care facilities go.

We think progress is being made on all those points and we don't have any real, serious grievance on those issues, and I think I can speak on behalf of most of the residents of our facilities. They may have apprehension about the future, but up until now they have not really

been seriously adversely affected.

But we feel the situation is not yet perfectly clear, that it has to be refined more. We feel that is a priority which should be worked on before they embark too vigorously on an MSA program for the community, as desirable as that program may be. We think it would be prudent to go slow on the MSA, review carefully the experience that has been established so far and to listen with care to the briefs that are being submitted by the various concerned groups.

I notice that the period for which time was allowed was extended, which is an indication of the general concern in the community, and I would imagine it would take a lot of work for your organization to prepare a summary of the briefs that you've received. I think it would be prudent to go slowly on the next step as far as MSAs are concerned until the long-term care has been further stabilized.

**Mr Jim Wilson:** Thank you. I think the bulk of the presentations—my guess would be 97% of the people who have appeared before us have such major concerns. Everybody starts off telling us they support the purpose of the bill, they support the bill of rights—and the way it's worded, frankly, it's motherhood. Who wouldn't support these things?

**Mr Kehoe:** That's right.

**Mr Jim Wilson:** But we're running into real problems. In fact, some of the more senior legislators around here indicate that they don't remember a time when the government's taken such a beating on a piece of legislation. So I agree. Would you suggest, as a number of groups have, that perhaps the government should, taking the advice that you talk about in terms of biting off more than it can chew, go the pilot project route or something with this legislation rather than the way we're going now?

**Mr Kehoe:** I'd be inclined to look at it very carefully as an alternative.

**Mr Jim Wilson:** Okay.

**Mr Kehoe:** Particularly as we, as an organization, have misgivings about the cost-effectiveness of the whole exercise.

**Mr Jim Wilson:** Thank you very much.

**Mr Kehoe:** If we were reassured on that point, we'd have more enthusiasm.

**The Acting Chair:** Mr Kehoe and Ms Glover, thank you very much for your presentation.

1500

BERNARD BETEL CENTRE FOR CREATIVE LIVING

**The Acting Chair:** Our next presentation will be made by the social action committee for the Bernard Betel Centre for Creative Living. Welcome to the committee.

**Ms Sheila Zane:** I am Sheila Zane, I'm the coordinator of the social action committee, and our chief spokesperson here will be Reta Duenisch-Turner, who is a member of our committee. There is also as well Sharon Zeiler, who is director of our wellness centre and our community centre.

**Ms Reta Duenisch-Turner:** We welcome the opportunity to present the views of the social action committee and the wellness committee of the Bernard Betel Centre for Creative Living on Bill 173, the Long-Term Care Act.

The Bernard Betel Centre for Creative Living is a non-profit, multicultural wellness centre located in North York which serves about 2,500 seniors living in the community. Our mission is to enable older adults to maintain their independence. We provide social, cultural, health and educational programs that improve the quality of life for seniors. This submission reflects the views of members of the Bernard Betel Centre for Creative Living who have a special interest in this reform.

We applaud the government for reforming the system that for many years has been fragmented and has not adequately met seniors' needs. We support the following principles in Bill 173: a single entry point to access services through the MSA, a continuum of service, a high-quality service, racial equality and cultural sensitivity, flexibility in MSAs, and consumer involvement.

We believe the objectives of the Long-Term Care Act to be most commendable. We are concerned with the realities of implementation.

Will there be enough money to provide quality and quantity of care at home for the seniors and disabled as need arises? Already we see there are waiting lists for services in the integrated homemaker program. Some of those who are receiving services are finding that their needs are not being adequately met. For instance, the average homemaker visit is only two hours per week, which barely allows time for laundry or housekeeping, not both. At present, there are waiting lists for home-making services. Being on a waiting list means no service at all. How can the government plan to ensure that there are sufficient funds to provide the quality of care that has been promised?

We worry about the apparent assumption that there is a family waiting and willing to care for our aging seniors. This is often not true. Many seniors live isolated lives, alone for a variety of reasons. Lack of adequate home care can be life-threatening to a frail or sick senior.

To improve distribution of homemaking service, one suggestion is to provide regular housekeeping and professional support service in seniors' apartment buildings. Thus, seniors requiring assistance would have it available onsite. Such personnel could accommodate the changing needs of the convalescent senior and aid those who require just a little help to remain independent and out of institutions.

We are concerned about the lack of institutional beds, both short- and long-term, for seniors if and when they need them. Patients are being discharged from acute care hospitals quicker and sicker than in the past. Ill seniors at home cannot manage with inadequate home services. Elderly family care givers, if available, are often unable to cope with the strain of meeting the care-giving demands. Elderly individuals have enough problems just caring for themselves. We'd like to suggest that an organized program of trained visiting volunteers from community agencies might supplement professional visits to convalescent seniors.

Another option is to increase the number of beds for convalescent care, either within existing hospitals or in any other care facility. Unused hospital beds and under-employed trained personnel should be utilized for people who do not need acute hospital care, yet cannot manage at home. I've had a bad personal experience where a friend of mine, a disabled person, was sent home from hospital alone when he should have been in a convalescent bed.

We are concerned about the inadequate number of long-term care beds available for seniors when they cannot be cared for at home. Today, people are living longer and, as a consequence, may be subject to many debilitating diseases which require more care than can be given at home. A person who has had a long and productive life has the right to spend her or his last days in dignity where they can receive appropriate care. How will the government ensure that a sufficient number of institutional beds will be available that will provide a high quality of care for people at the end of their lives?

We would also like to emphasize the importance of respite care for primary care givers. Primary care givers work long and hard hours and often need a break. Primary care givers must have support. In particular, there should be a contingent emergency plan for those care givers/providers who become ill while providing care. Respite care for care givers should include in-home services so that the care giver can have a short break, and respite care beds must be made available to the ill or frail person so that the care giver can have longer relief. Unused acute care hospital beds must be made available for this purpose.

At present, many agencies depend a great deal upon volunteers to help man their programs. Will the MSAs be able to retain the loyalty and commitment of volunteers to their programs? We are concerned that the heart of the volunteer's commitment will be lost within an arm's-length organization like the MSA. The government should provide support, recognition, incentives and training as encouragement to volunteers. Volunteers should be compensated for out-of-pocket expenses such as transportation, conferences and administrative support. On the other hand, there should be volunteer education management by the staff of the MSAs so that it will be understood that volunteers are part of the team, not just there to be used.

We believe the Long-Term Care Act does not recognize the importance of preventive wellness programs that keep seniors mentally and physically active in the community. We believe the continuum of care begins with the well elderly. Elderly persons centres and wellness centres provide valuable social, cultural, health and educational programs that improve the quality of life for seniors in the community.

Older adult centres often help to alleviate the loneliness and isolation that can lead to mental and physical deterioration of seniors at home alone. Preventive/wellness programs can help to delay the onset of disease which requires expensive medical costs. Many studies show that physical activity helps seniors stay healthy and moderates the complications of such major

illnesses as osteoporosis, arthritis, heart disease, diabetes etc.

Mental stimulation is as important as physical activity in keeping seniors well. Dr James Birren of the University of California states, "Mental activity is more necessary to successful living in old age than even housing or income." Another study, by Aseneth LaRue and Lissy Jarik from Brentwood Veterans Hospital in Los Angeles, California, studied people between the ages of 60 and 90 and concluded that memory loss is more the result of a lack of vocational and intellectual stimulation and the effects of depression than old age.

Because we believe so strongly that the continuum of long-term care should start with the well senior, we ask that older adult centres be considered part of long-term care and be funded accordingly. The programs at the Betel Centre for Creative Living, ranging from current events to tai chi to crafts, have made a world of difference to many of our members who have suffered from severe illness and mental depression. Many people come there every day and it's just like a second home.

An example of the depth and breadth of programs offered by senior centres and wellness centres can be found in the attached newsletter, the Monitor. We are also attaching excerpts from letters to our members that were quoted in the Bernard Betel Centre for Creative Living's submission to the Ontario Royal Commission on Learning in November 1993.

In closing, we support the government's initiative in reforming the long-term care system. We applaud the ideals expressed. While seniors recognize the importance of a streamlined and cost-effective system of long-term care, we hope and pray it will not be achieved by sacrificing the dignity and personality of each individual. We want the government to have a system whereby bureaucratic red tape will be at a minimum and personal contact will be maximized. Seniors do not want a cookie-cutter approach. Personal needs must be recognized. We want to have choices and we want to maintain control of our own lives.

We thank you for the opportunity to present our views.  
**1510**

**Ms Carter:** Thank you for your presentation and your concerned interest. I have been to the Bernard Betel Centre a couple of times, and in both cases you were doing your part in stimulating people by having panels and discussions. That was good to see.

I just wanted to comment on some of your concerns and maybe have your comments back. You're worried about money. Who isn't? There's never enough money for what we'd like to do, but I think part of the motivation of what we're doing is to make sure the money that's in the system is used for front-line services and not wasted on duplicating administration and getting lost in the system in that way. Of course, we are putting quite a lot of extra money in.

I think, quite rightly, you are especially concerned about homemaking services. I believe we've already put quite a large amount of extra money into that, and I believe as many as 5,000 extra people have been

employed as homemakers. So whatever the situation is now, it would have been a lot worse if we hadn't done those things. I certainly hope it's more adequate than you seem to suggest.

Another thing that strikes me about your presentation is that you're talking about acute care beds on the one hand, and the need for wellness and keeping people well and stimulating them and so on on the other. We had a presentation this morning which pointed out something called On Lok, in California, which you may have heard of, where apparently they only take on people who are at the point where they would normally be admitted to an institution, and yet 95% of those people are not in an institution as a result of all the other assistance that they're given.

I don't think we can get straight to that, but I think what we're looking at here is a tradeoff between having sufficient acute care beds but nevertheless working on not needing so many because of all the other things we're doing. So I think we all agree that we don't want to cut beds that are actually needed, but on the other hand, looking at the long term, we shouldn't need as many because hopefully we're going to help people to keep well. Do you have any comment on that?

**Ms Duenisch-Turner:** My friend was sent home alone—he's completely paralysed all down his left side—and nobody knew he was coming. He had been resuscitated back to life and, from the medication they had given him, he had acute diarrhea. I took him to the hospital at 2 o'clock in the morning, stayed with him until 9 o'clock, then went home—I live in the same building as he did—cleaned up his apartment and went home to bed. The manager of the building came and knocked at my door to say he was there. I felt quite disgusted at this kind of care. It's like a body being dumped, as far as I was concerned. I'm still very angry, and we did approach Ruth Grier about that.

**Ms Carter:** Obviously you're right that that shouldn't happen.

**Ms Duenisch-Turner:** He maybe didn't need an acute care bed, but he certainly wasn't ready to go home, and there needs to be something in the middle.

**Ms Carter:** I understand that the ministry has set up quick response teams to deal with that kind of situation. I wonder if we could have some comment through the parliamentary assistant on that.

**Mr Wessinger:** I'm going to ask Mr Quirt to indicate how a quick response team might have responded in this type of situation.

**Mr Quirt:** We have established, I believe, 20 new quick response teams across the province where we attempt to avoid hospital admission for someone who shows up in an emergency situation at the emergency department. If there's any way that resources can be quickly pulled together to allow someone to be served at home, that's what we're able to do. For example, immediately sending someone home on a 24-hour basis with a client might be an alternative to admitting them.

But in terms of your comment of an alternative place for someone to go or convalesce prior to them going

home, we certainly are making that type of short-stay program available in each of our long-term care facilities, in that there is a separate set of policies that apply to people who would be admitted to a nursing home or a home for the aged for a short period of time for the express purpose of regaining their strength and moving back home. That's something that wasn't possible in the previous system and it's something that's gaining importance in the system currently.

**Ms Sharon Zeiler:** Is it possible for me to just add that apparently right now there are people who are on waiting lists. They are ready to be discharged to a more convalescent type of situation, they don't need the hospital bed, but there are still long waiting lists for people who cannot get into them. I know of several cases personally. Our suggestion and our submission was that we do already have hospital beds that are closed, we have underemployed staff in hospitals, so could we not use resources we already have in a more imaginative way so that we could help people, say, for a short stay of a week or two, just to help them get on their feet so that they could come home, have resources in the community which would help them?

**Ms Carter:** Of course your comments on respite care are very relevant too, so that the care provider, if they become sick, can be looked after, or they can be given a chance to go on vacation. I believe that is built into Bill 101, that all nursing homes must keep some beds vacant for temporary use so that somebody can go in for two weeks or whatever. I certainly believe that is being built into Bill 173 as well.

**Ms Duenisch-Turner:** I'd like to ask about that, because I've a friend who had needed respite care—she was taking care of her Alzheimer's mother—and she couldn't afford it. I think there shouldn't be a fee for service when people simply—I mean, she had practically gone bankrupt. She didn't lose her house but she came very close to it by giving up her job to take care of her mother, and then she found when she needed the care that she'd have to pay for it. I just don't think that's fair. She lost in every way. She cashed in her RRSPs. That's a typical woman. She's going to live the rest of her life penniless, because she's now 66.

**Ms Carter:** I agree with you that we mustn't overburden the mostly women who take on care of elderly relatives.

**Ms Duenisch-Turner:** There's a physical and a financial burden, a great financial burden.

**Ms Carter:** Are there any comments as to how this is taken care of in Bill 173?

**Mr Jackson:** Or a year later it hasn't been fixed in Bill 101. Mr Quirt might like to comment on that.

**Mr Wessinger:** Certainly, Bill 173 provides for respite care. Respite care is not only the care within institutions but also would include in-home respite care. The new structure would hopefully provide this type of in-home respite care more effectively than we have under the present system.

**The Chair:** Thank you for coming before the committee this afternoon and making your presentation.

1520

FAMILIES' ASSOCIATION  
OF OAKLANDS REGIONAL CENTRE

**The Chair:** If I could call on our next presenter, from the Families' Association of Oaklands Regional Centre. I believe it's Miss Rhodes who's here, and your colleague is not able to be with us today, I understand.

**Mrs Catherine Rhodes:** I am Catherine Rhodes. I'm the parent of a resident at Oaklands Regional Centre. Kit Nero was supposed to be presenting with me this afternoon. She is also a mother of a resident at Oaklands Regional Centre, but something came up very suddenly last night which has prevented her from attending.

Oaklands Regional Centre, as many of you here already know, is a schedule 2 facility serving people with developmental disabilities. It's located in the heart of Oakville and it's run by a board of directors from the community. The Families' Association of Oaklands Regional Centre is a group of 127 persons whose purpose it is to act in support of Oaklands Regional Centre and its residents. Each member of this organization is a relative or legal guardian of an Oaklands resident, and I present on their behalf today.

There are just two areas that I'd like to touch on this afternoon; the first one has to do with a review. In March 1993 our group made a presentation to this committee in which we expressed concern that people with developmental disabilities were being denied access to the provisions of Bill 101. The following month, in April 1993, Partnerships in Long-Term Care, which is a policy framework publication of the ministries of Health, Community and Social Services and Citizenship, made the following statement:

"For a long time people with developmental disabilities and their families have urged that there be greater equity in serving their wide range of needs.

"Beginning within the next three years there will be a review of the two systems, long-term care and services for those with developmental disabilities, to produce a better-coordinated efficient system that reflects the concerns of the consumers, their families and providers."

The Families' Association of Oaklands Regional Centre would like to learn about the progress to date of the announced review.

We commend the action of the Ministry of Community and Social Services in arranging a grant to the Centre for Health Promotion of the University of Toronto to conduct a province-wide, four-year longitudinal study assessing the effect on quality of life brought about by different changes of environment in the lives of about 450 to 500 people with extensive ranges of levels of developmental disabilities.

The University of Toronto is an institution of excellent reputation. The findings, based as they will be in Ontario, will be a most valuable resource in the future. There is, however, a great deal of activity taking place in the province now whereby many people with developmental disabilities are being moved to different settings and environments. This includes from facility to community-based as well as from one community setting to another.

A great deal can happen in the lives of a great many people in the next four years.

There are research publications and outcome studies which also deal with the issues involved in such moves which are available now. One example, a British longitudinal study from the University of Kent completed in 1992, examines, in addition to the effects on quality of life, the cost-effective issues of moving from a hospital to a community setting as well as factors contributing to the failure or success of such a move. We submit that currently available information from such well-founded academic sources is needed and should be included in the triministry review process from the early stages.

We further maintain that consultations with senior clinical professionals in the field of developmental disabilities are an essential component of an effective review and should be included in this process. The disciplines of these specialists in developmental disabilities should include psychiatry, psychology, social work, physiotherapy and other related specialties. Their knowledge and experience of the special needs of those with developmental disabilities, combined with their abilities to interpret and apply related research, will contribute greatly to the goal expressed of "a better-coordinated efficient system."

The participation of family members representing those with complex and severe disabilities is also needed in the review, not only because of their experience but also because of their direct knowledge of the choices and preferences of those consumers who are unable to express these things effectively for themselves.

Touching on Bill 173, the legislation proposed in the present Bill 173 addresses provisions for persons with long-term care needs as well. It does not make a distinction between physical and developmental disabilities. In part XII, the continuing need for facility-based alternatives for some individuals is acknowledged in the proposed amendments to existing legislation relating to this level of care.

We ask from government the assurance that well-designed and appropriate specialized facility-based care, such as we have at Oaklands, will be available in the future for those persons with developmental disabilities who need such care. These persons would include people with complex and severe disabilities who require consistent and continuing involvement of a multidisciplinary team of clinical professionals and trained direct-care staff in an environment adapted to their special needs. This level of consistent specialized care and environment has been demonstrated to be difficult and also much more costly to replicate adequately in a community-based setting. There is documentation for this available.

Moreover, for many individuals with complex and severe handicaps of this degree, an appropriate congregate care setting provides ongoing opportunities for accepting, meaningful social interaction with other residents, staff from many areas, as well as volunteers and visitors from the community, combined with vocational and leisure activities out in the community.

The Families' Association of Oaklands Regional Centre strongly supports community-based alternatives for

the many persons with developmental disabilities for whom this is certainly the best choice. We continue, however, to maintain that well-designed, appropriate congregate care settings which actively promote community involvement and support while providing the required individual specialized care are the best alternatives for the other individuals with more complex and severe disabilities.

Long-term care and a variety of other services for people with developmental disabilities are primarily the responsibility of the Ministry of Community and Social Services. We expect the Ontario government to reflect consistently in every ministry the principle of equity of access to the full spectrum of whatever special services and care best meet the individual needs of its citizens. We submit that the concept of coordinated access to a full range of care and services, as outlined in Bill 173, whether community-based or facility-based, should be applied to all citizens according to their individual needs and must include people with severe and complex disabilities characterized by highly specialized needs.

The summary is pretty well what has gone before. The ministries of Health and Community and Social Services were jointly involved in Bill 101, which also dealt with long-term care and services. They published a related policy framework statement in April 1993, *Partnerships in Long-Term Care*, in which they announced a review of long-term care and services for those with developmental disabilities. Current, well-founded academic research available now and directly related to the purposes of the review, as well as consultations with clinical professionals specializing in developmental disabilities, need to be an ongoing component of the review process from the early stages. Families of people with severe developmental disabilities who cannot express their choices and preferences effectively should also be included.

Bill 173 proposes a coordinated continuum of long-term care and service options ranging from numerous community-based services to facility-based care. Citizens of Ontario with developmental disabilities have the right of access to a full continuum of specialized services and care which their individual needs require, regardless of the nature of their disability.

So the recommendations from the Families' Association of Oaklands Regional Centre include that the right of access for citizens of Ontario with developmental disabilities to a full continuum of specialized long-term care services and facility-based care which meets their individual needs be affirmed by the ministries of Health, Community and Social Services and Citizenship and that the regulations and policies of all Ontario government ministries reflect this affirmation.

We recommend that information be made available to consumers, their families and providers on the content, the participants and the progress of the review of long-term care and services for those with developmental disabilities, which was announced in the policy framework statement *Partnerships in Long-Term Care* in April 1993.

We recommend that consultations with clinical professionals specializing in developmental disabilities be

included as an essential and ongoing component of the triministry review process.

We recommend that well-founded longitudinal research studies directly related to the triministry review and currently available be included from the early stages and as an ongoing component of the review.

Finally, we recommend that family members be included in the review process to represent those individuals with developmental disabilities who are unable to express their choices and preferences effectively.

The Families' Association of Oaklands Regional Centre asks you to consider our recommendations and support their implementation. We thank you for your attention to our presentation.

**1530**

**Mrs Sullivan:** Thank you very much. Mr Chairman, as you will know from other sessions, the Oaklands Regional Centre is located in Halton and serves many people from my constituency as well as those constituencies which are to the south and to the north of mine.

I have been meeting with the parents' association for several years with respect to their fundamental concern, which is that as changes occur they are made on the basis of the ability and the capacity of the individual to take advantage of change rather than being forced into change. I think the parents' association has been very forthright with respect to its requests and demands that the needs be met as well as just a policy directive being implemented willy-nilly.

I'm very interested in the first point that you've raised in your recommendations with respect to the study which is being done. I wonder if we could have an update now from Mr Quirt or from the parliamentary assistant with respect to the status of the study of the long-term care reform and the needs of those with developmental difficulties and indeed also what clinical expertise and new research is involved in that review process.

**Mr Wessinger:** I can only answer some of the questions. First of all, people with developmental disabilities can access the long-term care services such as home care on the same eligibility criteria as any other person. With respect to the review, this review is not being conducted by the Ministry of Health but is being conducted by the Ministry of Community and Social Services, and unfortunately we don't have the expertise here available of anybody from the Ministry of Community and Social Services who can give an answer as to the status of that review. Mr Quirt would be unable to give you any more information than I have. The review is under the jurisdiction of that ministry, and to what extent it has progressed I can't give you any indication.

**Mrs Sullivan:** I find that very disturbing in that long-term care reform will fundamentally affect those with developmental delays and handicaps and a facility such as Oaklands Regional Centre, although it has traditionally been funded under Comsoc and so on and it's Comsoc policies that are under review. In fact, surely in long-term care the fundamental premise is that the health and the social services areas of long-term care will come together in the long-term care secretariat.

We raised this issue during Bill 101. We were told at that time that the developmentally delayed were simply left out. So I guess I'm going to have to ask the question again. You say they're in, but are they truly in? Are they really a part of long-term care reform?

**Mr Wessenger:** I think we should remember that the services under the Developmental Services Act are provided under the Comsoc ministry, and they have a budget of approximately \$1 billion, which is somewhat similar to the community budget in long-term care for all aspects under the Ministry of Health. So we have existing services provided at a budget equivalent to what is almost being provided for long-term care in the community.

I don't know whether the presenter wants to see those two systems integrated. Certainly that's, I understand, the purpose of the review, to look at the question of integrating the two systems, but it's a very substantial, separate provision of services to the developmentally handicapped under the Ministry of Community and Social Services.

**The Chair:** Mrs Rhodes, did you wish to comment?

**Mrs Rhodes:** Yes. I suppose, Mr Wessenger, we received some encouragement that the announcement of the review came not from any one ministry but from the triministry group which was behind Bill 101 and which issued this policy statement. So we thought just what Mrs Sullivan was suggesting was coming into play. If we had a bit more information on what was going on, perhaps we could respond in a different way. We haven't had anything since this in April 1993, and then Bill 101 was proclaimed. So we wait to hear a bit of the progress, who is doing it, who is participating. Except for that one research study, which sounds wonderful but it won't be ready for four years—and there is, as I mentioned, so much going on now, moving people about, that we're concerned.

**Mr Wessenger:** I certainly understand your concerns.

**Mrs Sullivan:** Could I ask the parliamentary assistant to undertake to provide the committee a report, through the interministerial triministry committee, with respect to the status of that review and what components are being addressed in the review.

**Mr Wessenger:** Certainly I think the committee could request that from the ministry.

**The Chair:** We will make that request. Mrs Rhodes, thank you very much for coming before the committee this afternoon. We appreciate it.

#### COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

**The Chair:** I call on our next presenters, representing the College of Dental Hygienists of Ontario. I just note for committee members that the college has also provided us with some background information and material, which is with the research staff.

**Ms Lynda Mckeown-Mickelson:** We are here today to present on behalf of the College of Dental Hygienists of Ontario. My name is Lynda Mckeown-Mickelson. I am president of the college. On my right is Don Page, the vice-president of the college and a public member, and Donna Bowes, who is the chair of the quality assurance committee and a professional member of the college.

Dental hygiene has grown up over the past 40 years

and is now independently regulated under the Regulated Health Professions Act; it's no longer controlled by dentistry. The mission statement of the College of Dental Hygienists of Ontario is to develop, advocate and regulate safe, effective dental hygiene practice for the promotion of oral health and the wellbeing of the public of Ontario.

Dental hygiene is not dentistry. Dental hygienists are trained and educated to emphasize the prevention of oral disease and the participation of the client in their own health. Therefore, dental hygiene is consistent with the paradigm shift from the medical treatment model of dentistry to the disease prevention, health promotion, wellness model.

Leaders of dental hygiene recognize that since its inception dental hygiene has emphasized the prevention of oral disease and the role of the client in controlling factors which cause disease. The uniqueness of dental hygiene as opposed to dentistry is its commitment to promoting human health, welfare and quality of life through knowledgeable oral hygiene services. Clients are encouraged to become actively involved in the health care process, not through compliance or dependence on the professional but in the form of a partnership or collaboration with health care professions.

Under the newly proclaimed Regulated Health Professions Act and the Dental Hygiene Act, the scope of practice of dental hygiene is the assessment of teeth and adjacent tissues and the treatment by preventive and therapeutic means.

I am now going to turn to Don and Donna to expand on our concern that oral hygiene services be included in long-term care.

#### 1540

**Mr Don Page:** Before proceeding, I'd like to emphasize I'm not a health professional. I'm an engineer by training. In the mid-1980s I was a member of the Rideau Valley District Health Council for six years, and for most of my term there I chaired the health promotion committee. I became very aware of the need to redirect our health expenditures more into the health promotion area if we are going to get our costs under control in the future. I think that's why we're here.

In my recent experience as a public member on the College of Dental Hygienists I have become very aware of the role that this new profession of dental hygienists can play in health promotion. I will follow our letter to you. We won't read from it entirely, but we'll take out the important bits.

The College of Dental Hygienists was established under the Dental Hygiene Act to regulate Ontario's 5,178 dental hygienists, with public interest as the guiding principle. The council of CDHO is composed of 12 members, six professional and six publicly appointed.

The council of the CDHO, having reviewed the Long-Term Care Act, Bill 173, wishes to bring to the attention of the members of the standing committee its concern regarding the omission of dental hygiene services from subsection 2(7). We consider this a serious oversight and one that calls into question the efficacy of the long-term care program as a whole.

The purposes of the act as stated are consistent with the scope of dental hygiene care, in that the primary focus is on prevention and health promotion. One of the goals of this act is to provide care and support to people in their own homes by ensuring "a wide range of community services" is available, thus providing an alternative to institutional care. Inherent in this goal is the assumption that the range of services and care will be comparable to those provided within the institutional setting. Residents within the institutional settings are provided with oral assessment, preventive services, as well as referral for treatment, and these same services should be available to persons being maintained in the community setting.

A further purpose of this act is to "simplify and improve access to a continuum of community services." The CDHO strongly supports the need for access to a continuum of services but stresses the need for oral health assessment as part of the continuum of health care services to be provided through the multiservice agencies.

**Ms Donna Bowes:** An additional goal of the act is concerned with the efficient management of services. Dental hygiene and dental hygienists provide a cost-effective, non-threatening, user-friendly and largely portable entry point into the dental care delivery system. Much of the long-term care population has difficulty accessing full dental care for cost or proximity reasons, or is fearful of the prospect of a visit to a dental office. Dental hygiene services delivered in the home would be far less intimidating, would effectively provide routine oral hygiene care and would identify conditions that require a dentist's attention, thereby making appropriate referrals.

The intent of the act is to support the home-bound, who are predominantly seniors, and a published study of the dental needs in some of Ontario's senior population demonstrated the requirement for dental hygiene care. Out of 607 dentate seniors—seniors with teeth—examined during the study, approximately 448 required dental hygiene services, and a further 75 required advanced periodontal services.

In the same study, it was reported that only 64% of the seniors interviewed had visited a dental office in the previous year. Not surprisingly, the majority of the seniors in need were in the more rural and northern parts of the province.

Having worked in public health for a number of years, where I was coordinating a geriatric dental program, I delivered care to the institutions but I also did some home visitations. I also did some work with hospice and palliative care. I've circulated some photographs to give you some idea of how very portable dental hygiene services can be. They can be as simple as carrying a bag of tools upstairs to visit the person in their own bedroom. We can provide services chairside, bedside, however they may be required.

The delivery of these services in the photographs that you have took place in Simcoe county under a pilot program that I developed and implemented. That pilot program is a one-of-a-kind program in the province of Ontario. Simcoe county is the only health unit that has a

program of this nature. It's been highly successful and highly touted as the program of the future. It's the way we should be going.

The program is extremely cost-effective. I spoke with Dr Terry Hicks, the dental director at that health unit, last Friday, and we reviewed the costs for the program for last year. The costs come out to \$25 to \$30 per client per year.

That client receives oral screening. They receive two preventive appointments a year. They also receive inservicing; in other words, instruction in the care that's required on a day-to-day basis. That's a very cost-effective program, and that's the kind of program a dental hygienist can deliver into a facility or into a home.

In future, with the focus on hospice and palliative care, I see there's going to be a great deal more need for oral services and oral care. Hospice patients and palliative care people have very specialized oral care needs, and those can be delivered at their bedside by a qualified and registered dental hygienist.

**Ms Mckeown-Mickelson:** There's a large body of literature on the positive impacts of routine oral health care for the aged, the mentally and physically disabled and for those in hospice care. Studies, particularly among the aged, have found high percentages of oral soft-tissue lesions, a high incidence of fractured, decayed or sensitive teeth, gum disease, ill-fitting dentures and poor levels of general oral hygiene.

One US study found that all of the hospice patients in a survey sample had gingival inflammation—swelling of the gums—and 75% evidenced some kind of pathological change in the oral mucosa. These conditions affect a person's ability to consume and enjoy food, affect social interaction and appearance, contribute unnecessarily to pain and erode the individual's morale and overall attitude. There is an abundance of scientific literature and research showing that the major cause of gingival inflammation, gum disease, oral disease is just poor oral hygiene. Bringing people to oral health and general health is good dental hygiene.

There's an interesting study that's been done in Ontario. The research indicates there are a good number of admissions to acute care facilities as a result of upper respiratory infections that appear to be directly related to the mouth and there are possible deaths resulting from aspiratory pneumonia, which is related to the mouth.

**Ms Bowes:** Even basic oral hygiene care can prevent or reduce the effects of many of these oral complications. Regular oral hygiene care also has positive and measurable effects on basic health and on specific medical conditions. For example, another US study found that regular oral hygiene care for patients with acute renal failure significantly reduced the occurrence of non-specific stomatitis—that's a redness and swelling in the mouth—but the benefit was neutralized if patients did not receive oral care for extended periods of time.

I'm the picture lady. The next picture is also mine. The picture really just demonstrates to you a typical senior's mouth, before and after dental hygiene care. This is one month apart, with four treatments from a dental hygienist.

There was no dentist involved in this care and in this treatment. This was a senior. This is an example of what can be done with regular dental hygiene care.

**Mr Page:** The CDHO requests that oral hygiene care be included in regulation as one of the personal hygiene activities under subsection 6(1). We've made a number of recommendations pertaining to Bill 173. I won't refer to them in detail, but they're in our letter.

If a multiservice agency is required to assess the needs of an individual, it would seem to us that the oral needs of the person are equally as important as other physical and social needs.

The CDHO would like to point out that the regulatory colleges are responsible for setting standards of practice for regulated health professionals. The regulations must indicate that any standards set by or for a multiservice agency must be in accordance with professional standards set by the appropriate college established under the Regulated Health Professions Act.

While we recognize the government's wish to contain the costs of the long-term care program and the concomitant wish to avoid setting a precedent by adding to the list of professional services, we believe that few professional services are as universally required in long-term care as oral hygiene.

We also believe that few professional services would have such a beneficial and cost-effective impact on a person's overall health, morale and outlook on life. Therefore, we strongly urge the committee to include dental hygiene as a professional service under subsection 2(7) of Bill 173.

We have provided one copy of each of the background papers referred to in our letter which are available for your use.

1550

**The Chair:** Thank you very much. I know those of us who have been through the RHPA hearings have built up a marvellous collection of slides, particularly from those in the dental field. You'll notice how carefully we scheduled you for later in the afternoon, not immediately after lunch.

We'll go to Mr Wilson.

**Mr Jim Wilson:** Thank you for your presentation on behalf of the College of Dental Hygienists of Ontario. I have a very simple question. You make a very persuasive case with respect to oral hygiene and you make the point that oral hygiene services are provided to people in institutional settings. Why do you keep getting left out of health care reform?

**Ms Bowes:** Excellent question. We ask ourselves that all the time. I think part of it deals with tradition. Dentistry has kind of divorced itself from the rest of the health care field, to a point where it's almost, "If it's in the mouth, it belongs to us," and nobody else wants to deal with it. That's probably partly our own fault. I do believe that we have to become much more interdisciplinary in our approach to health care.

I would hope that in the future, as health professionals are trained, there will be a method of coordinating their education so that people understand that oral health is a

part of the entire body's health.

**Mr Jim Wilson:** Maybe we could ask the parliamentary assistant with respect to two areas here. Very generally, what is the ministry's intention with respect to oral health? It isn't mentioned under this legislation.

More particularly with respect to assessments, one would think you would want to make sure, if you're doing a thorough assessment of a client, that oral health would be included. As part of what I assume you will adopt, which is a multidisciplinary team approach, how will hygienists or dentists, for example, be included in that approach?

**Mr Wessenger:** If we look at the act, there's no requirement of any mandatory provision with respect to dental services. However, I would suggest that certainly an assessment could be involved as far as requesting the expertise of someone, either a dentist or a dental hygienist.

With respect to the whole question of providing services, of course that's really the whole question of whether we extend our health care system to provide dental services. Certainly I would suggest that maybe there are other alternative methods. As indicated by the presenter, the public health unit under Dr Terry Hicks has a very cost-effective method of providing dental care to seniors.

That might be the question I'd ask the group. Maybe that might be the preferable model, rather than under the provisions of long-term care, because that would give a broader coverage for seniors. If you provide it in the long-term care aspect, you're really only covering those seniors who would be entitled to long-term care. So just a comment and a question that if we're going to move in that direction, which I think we'd all certainly like to do if financial circumstances permit, then it would be better to have a more comprehensive coverage than just those who would be eligible for long-term care services. That's just my comment.

**Mr Jim Wilson:** That's interesting, if I may just interrupt, though. You're making it very clear that this bill is restricted to the sick elderly, which is something we get conflicting comments about from the government. But surely, given that the evidence has been around for many years about the need for good oral hygiene services, that they've been contemplated by the ministry under this act—because you're setting up a monopoly called an MSA, and if they're not part of its basket of services, then I don't know how you'd be extending funding for these services in the future, if not through the MSA model that you're setting up.

**Mr Wessenger:** I'd suggest there are various models for delivery and the MSA model is one that could be considered.

**The Chair:** Did you want to comment on the earlier comment?

**Ms Bowes:** I suspect you're alluding to turning everything over to public health, and having been involved in the field, I know very well public health is terribly underfunded. They don't have the staff to carry out these kinds of programs.

If you're going to implement programs like this, at this point anyway, it's a rob-Peter-to-pay-Paul kind of thing. We managed in our county to produce this program, but at a cost. We had to discontinue a number of other public health programs in order to fund this particular program, but we decided it was a requirement. We needed the service and we did it.

I'm afraid that out of 42 health units in Ontario, I would hazard a guess that about 15% are prepared to undertake anything like this. Unless the funding is going to increase to public health, I don't think you're going to see these kinds of services across the board.

**Mr Jim Wilson:** Can we just make it clear for the record? Who's paying for the oral hygiene services that are provided now in the institutional settings? For instance, in our local nursing homes, now called long-term care facilities, in Simcoe county there are services provided. Is the consumer paying for those on a user-fee basis, or is the county picking it up?

**Ms Bowes:** In Simcoe county they're provided through the public health unit.

**Mr Jim Wilson:** Is that the case in most areas?

**Ms Bowes:** I understand that the few health units that are involved, such as North York, Scarborough and Ottawa, are doing very minimal services, but again, they are also being provided through the public health sector. I'm not aware of any private people providing services at the present time, not through not wanting to, but through legislation prohibiting them from doing so in the past.

I understand the Ministry of Community and Social Services and the Ministry of Health have produced the newest standards for accreditation for institutions, and my understanding now is that the institutions are scrambling around saying: "How are we going to meet these accreditation standards? Who's going to provide this care?" It's been kind of left up in the air as to how it's going to be provided.

If you can persuade your health unit to do it, wonderful. Otherwise, I understand some of the community colleges have been approached to have students provide it. There will be a variety of ways in which these institutions will get out there and try to meet these standards.

**The Chair:** Thank you all very much for your presentation before the committee this afternoon for your presentation. 1600

**Mrs Sullivan:** Mr Chairman, I wonder if I could also ask the ministry for an additional briefing note and comments. We've had at least two representations with respect to children's services and how they will be dealt with under this bill, and I'm quite deeply concerned that we have not had information about where the children's treatment centres fit and how other children's services will be delivered when young people require long-term care services and facilities, whether in the home or in the community.

We apparently won't have time during the public hearings for an additional briefing from the ministry, so I'm asking therefore to see something quite definitive on paper before we get into the clause-by-clause, because I think there are some major public policy issues there.

#### ONTARIO ASSOCIATION OF PROFESSIONAL SOCIAL WORKERS

**The Chair:** I call on the Ontario Association of Professional Social Workers. Welcome to the committee.

**Mr Dan Andreae:** My name is Dan Andreae and I'm the president of the Ontario Association of Professional Social Workers. I'm joined by Lesley Patterson, who is a social worker at the Baycrest Centre for Geriatric Care. She has been the chairperson of the OAPSW Metro branch's aging committee for several years and is currently serving on the association's provincial aging committee. Lesley will present the association's position on Bill 173.

Also in attendance is Joan MacKenzie Davies, our esteemed executive director of OAPSW, and Gillian McCloskey, the associate director. I believe there will be no major decisions made in the association for the next 20 minutes because we're all here to support the important presentation you're about to hear.

As many of you know from previous appearances at the standing committee on social development, OAPSW is the body representing professional social work in Ontario. We are an active membership organization and there are currently in excess of 3,100 social work members representing all areas of Ontario.

One of the major tasks that we are involved in is social advocacy, and it is in this capacity that we are presenting today, drawing on the extensive and intensive experience of the profession in dealing with this issue and the elderly in areas such as counselling, program planning and policy development. We've had a considerable amount of experience, as many of you know, with dealing in this particular issue for a number of years.

Ms Patterson will outline in the next several minutes the ways in which OAPSW supports this legislation. She will raise certain concerns that we indeed do have and will also demonstrate the ways in which social work, we hope, will play and should play a major and crucial role with the quality care that's required for this legislation.

**Ms Lesley Patterson:** The OAPSW continues to follow with interest the reform of long-term care in the province. We endorse the government's commitment to developing a coordinated system of services to meet the needs of the elderly and of people living with disabilities. This is reflected in Bill 173, An Act respecting Long-Term Care.

In order to create a more equitable, accessible and effective service delivery system, OAPSW supports initiatives aimed at strengthening and consolidating community services. We regard the provision of social work services as an integral part of long-term care, in accordance with the profession's focus on addressing the interaction between the individual and his or her environment, and the belief that this interaction affects the individual's ability to accomplish their life tasks and maintain quality of life. Social workers are attuned to the multiple needs associated with one's physical, social and psychological wellbeing, and therefore strongly advocate for a more holistic service delivery system.

In January 1991, OAPSW produced a response to

Strategies for Change: Comprehensive Reform of Ontario's Long-Term and Support Care Services and, in 1992, to Redirection of Long-Term Care and Support Services in Ontario. In January 1993 our association also submitted a response to Community-Based Services Provided by Multi-Service Agencies. These documents are all enclosed for your information.

Our association fully supports the spirit of Bill 173 and the comprehensive nature of this proposed legislation. We are also pleased to observe how feedback gleaned from the consultation process is reflected in the bill. For example, the social work profession is no longer restricted to illness, disability and bereavement, as we had suggested in our response to Community-Based Services Provided by Multi-Service Agencies.

Regarding Bill 173, the following points reflect OAPSW's main concerns and our recommendations as to how implementation of this major piece of legislation can be fine-tuned.

Our first concern is around consumer needs and funding. The OAPSW supports the major tenets of Bill 173. However, we are concerned that economic pressures may result in significant altering of the fundamental principles and, further, that funds may not be available to implement the legislation in its entirety. Such a reduction could place the vulnerable elderly and disabled groups in an untenable position, with reduced institutional care and inadequate community care.

If the government decides not to follow through on its proposed increase for community care funding, home care services may not adequately replace the disappearing institutional and medical services. There are two major issues regarding the implications of this.

First, if formal home care is inadequately funded, care givers will undoubtedly suffer from major repercussions. As has been well documented in the gerontological literature, the vast majority of care for the elderly comes not only from the formal health and social care system, but informal care givers—for example, family and friends—and the vast majority of these are women. Cutbacks in medical care will further increase the demands on the care givers and may put many at risk with respect to their physical, mental and financial wellbeing. Many already suffer from "care giver burnout."

Second, the reduced institutional care and inadequate community care would severely restrict consumers' choices and control of their use of services. Consumers and their families could find themselves struggling with case managers who'd be forced to fit the individuals into whatever resources were available. Anyone who expressed needs that did not fit the available services could potentially be identified as problematic. Thus, it's imperative to increase community home care services in order to compensate for cutbacks in medical service. Further, it is essential that effective and adequate care and support be maintained in both the institutional and community care networks so that the needs of the elderly or disabled adults and their care givers will be given paramount consideration.

Because Bill 173 is a response to consumer needs,

implementation should reflect this direction. MSAs will now be recognized as the sole information and referral sources regarding long-term care services. However, there's a potential danger that seniors will now be assessed and advised on the services they need instead of determining for themselves what services they want and how they should be provided. There may not be a choice for consumers and their families between facility- or community-based services.

Finally, regarding consumer needs, we urge that special attention be given to those people wishing to access resources within the long-term care service delivery system. These people often constitute the most vulnerable in society and include a large number of women. These individuals are often both the recipients of care and also the informal or formal care givers, and frequently they are visible minorities and below the poverty line. Each of these disadvantaged consumer groups faces a unique set of barriers to accessing long-term care services.

For example, recent literature suggests that ethnic minority seniors have unequal access to both health and social services, mainly because these services cater to the needs of the dominant culture in Ontario. Access to knowledge about these services is restricted for ethnic seniors since service providers seldom publish materials or advertise in languages other than English or French. In addition, interventions that are offered tend to be culturally inappropriate to the expressed needs of these consumers. The government is urged to take into consideration the literature available regarding the special issues that each of these consumer groups faces and to adapt practical recommendations made by experts in the appropriate fields.

Our second concern was regarding social work role and definition. The OAPSW is pleased that in the compendium social work was included in the list of health professionals. Social work is a key component in the long-term care system because it's the only discipline where training, education, basic principles and the professional activities specifically target maximizing individuals' personal strengths. The systems approach inherent in all social work practice is ideally suited to viewing individuals within the context of their families and the broader communities in which they live.

OAPSW is concerned about how the flexibility of providing low-cost, non-professional staff may be applied. Our association has developed parameters for the scope of duties recommended for graduates at the bachelor's and master's level. One related area of confusion noted in the bill relates to a certain blurring in the use of the terms "social work" or "social work services" and the term "social services." The term "social services" rather than "social work services" may be used to justify the use of untrained personnel to engage in social work practice. Unfortunately, the lack of a social work act has led to rampant use of this strategy. To clarify, enclosed are the social work definition and the scope of practice as developed by our board of directors in 1994.

Our third concern is the case manager role. The role of the case manager is central to implementing the content and the spirit of the act. The practice of case management

involves a number of functions, namely, intake and assessment of needs, setting goals, developing a plan of action which may include counselling, referral to appropriate resources, advocacy on behalf of clients, monitoring and reassessing the client's situation and needs, and, finally, systems advocacy.

Training in counselling and the ability to address psychosocial needs in a timely manner, combined with skills in resource-finding and efficient utilization of existing resources, make social workers particularly suited to matching clients with the most cost-effective and least intrusive services to meet safety and independence needs. Our wellness-oriented focus on competency building and preventive action encourages clients' independence. Our consumer advocacy adds to the match of social work skills with the defined case manager role. We believe that these factors combined make trained social workers the natural choice as case managers.

1610

Our fourth concern regards facility reforms and fees. Eliminating the discrepancy between the fees and the services offered at nursing homes and homes for the aged is a welcome reform. Recent fee hikes, however, have placed a burden on residents who were once able to pay for private or semi-private accommodation and must now scale down. It had also created a backlog of residents waiting for semi-private rooms or ward beds within facilities. This makes entry to facilities at the ward level more difficult for applicants who are applying from outside. Also, if it is intended that the fee hikes will be contributing to the \$200 million that was to be allocated to nursing homes and homes for the aged, we would suggest that the government explore the percentage of residents who are actually paying for the new rates for ward, semi-private and private accommodations in long-term care facilities.

In summary, OAPSW supports and applauds Bill 173's intent and direction, although we are concerned that economic restraints will adversely affect the implementation of this legislation. We strongly recommend that cutbacks not be made, since this would have adverse effects on consumers and their families. In practice as well as in principle, Bill 173 should empower the elderly and the disabled and their care givers by giving them flexible choice over their use of services.

Consumers can be empowered only if there are adequate sources of institutional as well as community care support. Disadvantaged groups such as those who are particularly frail, vulnerable, fall below the poverty line or are visible minorities have very limited access to services and policies, which should be given special consideration.

It is recommended that the government incorporate policies which would work towards dissolving the barriers that these consumer groups face. Attention also needs to be given to the implications of recent fee hikes for current and prospective residents of long-term care facilities.

Our association is also concerned about how the flexibility of providing lower-cost, non-professional staff may be applied. Based on academic knowledge and

training, professional skills and expertise, social workers carry out daily case management functions, including assessment, coordination, counselling and advocacy.

In light of this, social workers have a unique and vital contribution to make to recipients of long-term care and to a more effective and efficient delivery system within this province. With a view of serving the best interests of Ontario's citizens, OAPSW sees the social work profession as a key player in the implementation of this legislation and we look forward to participating in a continuing dialogue with government.

**The Chair:** Thank you very much for the presentation and also, as you indicated, copies of both your submissions in 1991 and 1992 and the definition of scope and practice for social work in Ontario that you prepared in February of this year. We'll go to questioning.

**Mr Gary Malkowski (York East):** Thank you for your presentation on the role of the social workers, and I feel that is a very key role in long-term care, as we're aware. I have a social work background and education, and so I think the social work field is very important. In my private member's bill I'll also be recognizing the importance of social workers.

But anyhow, talking about your concerns related to the freedom of choice for consumers and your concerns about limitations in the institutions and in the community care services because of the funding situation, I want you to know that our government has already spent \$850 million—that's an increase in community-based services—during 1993-94. Then next year, in 1994-95, they'll be spending over \$1 billion, and that's an increase of funding to community-based services. Currently, though, at the same time the federal government is thinking about cuts in transfer payments to the provinces and that will have an economic impact, so we have to be concerned about that.

Can you tell me about the impact for coordination of service? Do you feel that the MSA legislation will broaden the choice for people for community-based services? What do you feel will be the impact there?

**Ms Patterson:** We haven't come up with an official response to the MSA, but I think, speaking as a social worker, one of our concerns is that by consolidating all the services in one basket, it could have a number of detrimental effects on clients. They might be intimidated, depending on the nature of the agency that ends up distributing the services. Naturally, there'll be competition for resources within that agency, and there's a whole question of who will have—I'm not quite sure how to phrase this—more strength within the agency. Will it be by demographics, the number of people in that area, or will it be by interest group, or just exactly what?

I think that one of our major concerns about the MSA is more around the area of assessment. There are a lot of seniors I have contact with who are looking for a very simple service, such as snow clearing or Meals on Wheels. They're not needing to be processed by a large bureaucracy; they're simply looking to call and get their simple service. We have some concerns around that. Is that clear?

**Mr Malkowski:** In my riding, the borough of East York, there are various services, although the community services are working together towards this goal, and it's not a competitive environment. The seniors and disabled people are working together to work on a model, work on an assessment process, and the consumers feel that it's beneficial that the assessment be holistic. I wonder what your recommendations are related to that for the assessment process and how it would alleviate your concerns in that area.

**Ms Patterson:** We'd certainly support a holistic approach. That's one of the things we're very strong on. In regard to assessment, I don't want to restate myself, but certainly we see the voluntary social worker as very integral to that, because we are trained to have sensitivity to the community and to the needs of the individuals.

**The Chair:** Thank you both very much for coming before the committee this afternoon.

ASSOCIATION OF DISTRICT HEALTH COUNCILS  
OF ONTARIO

**The Chair:** I next call on the representatives from the Association of District Health Councils of Ontario. We want to welcome you this afternoon.

**Mr Ken Whiteford:** I'm accompanied today by John Court, the assistant executive director of the association, and the vice-chair of the association, Susan Brown. My name is Ken Whiteford and I'm the chair of the association. John Butler, who I think was shown on your program as being present, was not able to attend. You have got a copy, I believe of our submission. I will simply try and highlight that, as opposed to going through it word for word.

Our association, which is called ADHCO in the acronym, is the collective voice and collective agent of Ontario's 33 district health councils. The DHCs, as you probably are aware, are schedule 3 agencies which advise the Ontario Minister of Health on matters relating to health needs in the community based on the principles of good planning and community consultation. The first DHC was created approximately 20 years ago and the most recent one, and the last one, was created just six months ago.

Since I think many DHCs have already spoken to you on a variety of topics related to the long-term care legislation, we would like to focus this afternoon specifically on those parts of the legislation referring to DHCs.

First, let me say that we generally support these provisions within the bill. We believe that embedding the role of DHCs in the legislation helps to both empower us and provides the residents of this province with a little bit of better understanding of the roles and responsibilities of DHCs.

We also believe that this legislation reflects a partnership among communities, DHCs and the Minister of Health. Most of our comments are directed at improving the language of certain sections so that they better represent that partnership. We acknowledge very clearly that DHCs are in fact the creation of the government of Ontario, but if DHCs are seen only as the arms of the government and not as the agents of their communities,

we believe our credibility would suffer.

First, in terms of the details of the legislation, we would like to refer to subsection 62(1), subsection 8.1(3), which deals with the criteria for appointments. We feel this section shows a keen understanding of the need to have DHC members who reflect the diversity of their communities. DHC members do not represent specific narrow interests, but the breadth of background is important to all of the members. We believe this particular section of the legislation does ensure that breadth of background is recognized.

1620

Secondly, in reference to 62(1), clause 8.1(4)(c) refers to the planning functions of DHCs. We feel this particular section should refer not only to the DHC planning for development of a better system but also to the need for the implementation of such a system and the planning for that implementation. Clearly, DHCs do not implement the results of their plans. However, one widespread criticism of planning in both the public and private sectors is the failure of good ideas to become implemented. We see planning for implementation as an activity which binds together planning and implementation, and we see it as consistent with the advisory nature of DHCs in general.

Another function cited under this section is the performance of "any other duties assigned to it under this or any other act or by the minister." We suggest that words be added to this section to state that these additional tasks would be based on an agreement between the minister and DHCs on the task. I think you can appreciate that any organization only does a job well if it believes in the value of the job and if it is helped to define the job in the first place. We see that being consistent with partnership.

**Ms Susan Brown:** Subsection 62(1), subsection 8.1(5) of the legislation refers to the aboriginal communities and the minister's ability to direct a DHC not to discharge one or more of its functions with respect to that community.

We respect and understand the need for aboriginal communities to plan for their own services. Nevertheless, much of the planning done by DHCs in a district or jurisdiction will be for generic services which are meant to help the population of the area, both aboriginal and non-aboriginal populations. Since it may prove very hard for any minister to make before-the-fact decisions on whether a piece of planning impinges on aboriginal autonomy, we would hope the minister would seldom use this legal option and that instead the minister might simply choose not to accept those DHC recommendations which may impinge on aboriginal autonomy.

Subsection 62(2): Clause 12(d.1) authorizes the minister to pass regulations on several matters, including recruitment of members of committees of a DHC. We view it as quite appropriate for regulations to be passed concerning membership on the actual boards of district health councils, but we believe that a reference to regulations on committees should be removed. DHCs need the freedom to create whatever structures they need, filled with whatever members they deem appropriate, a community mix for their community to do the work that needs to be done. Regulations governing this aspect of

DHCs could stifle local creativity and responsiveness and might become the cookie-cutter approach which we believe the minister would like to avoid.

Lastly, we are aware that the legislation does not mention regional planning. We acknowledge that in its brief to you, the Ontario Hospital Association expressed concern about the creation of a southwestern Ontario regional planning body which OHA describes as a layer of bureaucracy to which DHCs would be subordinate. OHA wants it made clear that no regional planning bodies will be created under the sections of this bill dealing with DHCs.

We, on the other hand, feel that regional planning has been done for years by district health councils as a cooperative activity. We do not feel that regional planning needs to be mentioned specifically in this legislation, since such mention is not needed to allow district health councils to continue this cooperative regional activity. Conversely, the absence of it in the bill should not be used to prevent district health councils from planning cooperatively with each other.

In summary, we support those sections of Bill 173 related specifically to district health councils. Although we propose a few changes which will help reinforce the idea of partnerships between communities, district health councils and the minister, we also appreciate the minister's expressed support for the involvement of DHCs in development of any amendments or regulations which might be passed in the future that pertain to them.

I also point out that we are not legislative experts. While we do propose specific wording changes, we are quite happy with alternative wording which might work equally well to express the concept of partnership which is so vital to the district health council system.

**Mr Dalton McGuinty (Ottawa South):** Thank you for your presentation. I want you to expand a little bit on the role you see aboriginal communities playing. We have heard from at least one representative of aboriginal communities, and I have a copy of another written submission, with respect to section 62 of the bill, subsection 8.1(5) of the act. I'm not sure if I've got the numbers right, but it's the one that's got "Aboriginal communities" marked in the column:

"If health services for an aboriginal community in a district health council's geographic area are planned, managed or delivered by the aboriginal community or by an aboriginal organization, or if resources for health services for the aboriginal community are allocated by the aboriginal community or by an aboriginal organization, the minister," and then it goes on in clauses (a) and (b) to say, "may direct the district health council not to exercise one or more of its functions..." and "may direct the district health council to cooperate with the aboriginal community...."

The aboriginal representatives are telling us that we should remove the "may" and replace it with "shall." I want to get your response to that, please.

**Mr Whiteford:** Let me fully understand, then. They wish to make it very clear that we not be involved, or involved?

**Mr McGuinty:** They want to make it mandatory rather than permissive on the minister's part: the minister must. If that condition has been satisfied that's set out at the beginning of subsection (5), then the minister must direct a district health council to cooperate or not to exercise one or more of its usual, I guess, powers.

**Mr Whiteford:** I don't think the district health councils would have any problem with that in terms of the use of the word "shall" instead of "may," if that was satisfactory to the aboriginal community. Our understanding is that the ministry is working with the aboriginals to determine exactly how they want their health care needs met in terms of planning and implementation.

I guess our point today was simply that if we're doing the planning for a broad general area, especially with generic services, it's very difficult to plan for islands within those regions or districts. Our point is that we feel we should be able to do the planning, but if certain parts are ignored, that's fine as well. And if they on the other hand feel that if the condition is met, that we "shall" do the planning, we would have no problem with that.

**Mr McGuinty:** Just to make it perfectly clear, would you object to an amendment which substituted the word "shall" for "may" in the section that I was referring to?

**Mr Whiteford:** You must appreciate that we haven't had an opportunity to study this in great depth and it may be something that we would wish to—

**The Chair:** The parliamentary assistant wants to make a comment on, I guess, the legalities of where that stands right now, which may help in your response.

**Mr Wessinger:** I thought it might be of some benefit to have legal counsel explain the significance of replacing "may" with "shall" and how it would relate to what your submission relates to.

1630

**Ms Gail Czukar:** The question that Mr McGuinty is putting with respect to subsection (5) of the district health council section would then say that as soon as there is planning, management or delivery activity on the part of an aboriginal community or an aboriginal organization, the minister then must direct the district health council not to do any planning or not to cooperate with the aboriginal community, that they're on their own.

It's difficult to see how the recommendation of that organization could be implemented when there are two alternatives in the section: One is to say that the minister can direct the district health council not to do one or more of the things that it does with respect to planning and recommending to the minister, or she can direct the district health council to cooperate with an aboriginal community to come to some agreement.

It seemed to me that your recommendation was that there could be some joint planning, and in fact aboriginal communities have asked that there be some joint planning in certain cases. It was meant to be a flexible section, so it's hard to see, legally at least, how you could do what was recommended, because the minister would have to, as soon as there was some activity on the part of that community, tell the district health council not to exercise its functions.

**Mr Whiteford:** I gather from your comments, then, that there may be some concern with the word "shall." I guess, from our standpoint, cooperation was the name of the game. We simply wanted to ensure that there was cooperation and coordination between the aboriginal communities and the DHCs within that district. If in some cases, which might happen, the aboriginal community decides to go off and do its own planning and the minister agrees to that, then we would appreciate and recognize the fact that our recommendations with respect to that aboriginal community may not be adhered to.

I think from our standpoint, in response to the original questioner, it might be best if as an association we got back to you on that point as to the "may" or the "shall," perhaps in writing to the clerk, and commented on it. Obviously, as just indicated, it has a number of different meanings and interpretations, so perhaps that would be the best. There are no lawyers on this side of the table.

**The Chair:** It's always nice to have lawyers in the room somewhere to ensure that we don't do all sorts of horrible and pernicious things. Sorry, it's late; the Chair is wandering a bit. Mr McGuinty, did you have anything further?

**Mr McGuinty:** No, those are my questions, thank you.

**The Chair:** If indeed there are any further thoughts you have on that, by all means send us a note and we'll take those into consideration as well. Thank you for coming here this afternoon.

#### ONTARIO FEDERATION OF LABOUR

**The Chair:** I call on the Ontario Federation of Labour, Julie Davis, secretary-treasurer. Ms Davis, welcome to the committee.

**Ms Julie Davis:** I also have with me Adrianna Tetley, who is on the federation staff. I figured the submission would take too long to read. That's why I reduced it to the key points in my speaking notes.

**The Chair:** We appreciate that.

**Ms Davis:** On behalf of the Ontario Federation of Labour, representing over 650,000 workers, I'd like to thank the standing committee on social development for the opportunity to present our response on Bill 173, the act to implement long-term care. The OFL represents both the users of the health care system and the front-line workers who deliver the care.

I'm proud to say that over the past year our movement has developed an action plan and strategy for genuine health care reform. We've brought health sector unions together in precedent-setting unity. We have reached out and joined hands with other labour federations and health care reformers across the country. In the appendices to our brief you will find labour's plan as well as a copy of what we endorse as the "10 Steps to Better Health in Canada."

Today, seniors' organizations, and we should all be grateful to them, are in the forefront of the struggle for better health care. We are pleased to stand with them in their call for the immediate passage of Bill 173. The government must pass Bill 173 in this term of your mandate so that Ontario can move forward on the long-

term care system that seniors have been demanding for years: a seamless, one-stop system that offers a continuum of care.

To seniors and care givers, multiservice agencies are the way to go. We must free ourselves from the current fragmented, uncoordinated and costly patchwork of services. We can't afford to waste over \$200 million a year administering this seriously inadequate system.

With MSAs, we calculate that we stand to save at least \$90 million in administration costs that must be applied to the delivery of much-needed front-line services. With a new name, new mandate and new identity, MSAs will not only create more jobs for front-line workers and dedicated volunteers, but will also make community fund-raising much easier to coordinate.

The OFL, along with the Ontario Coalition of Senior Citizens' Organizations, the consumer alliance and other seniors' organizations, calls on the Ontario government to muster the courage to stand up to the agencies who oppose the changes. We believe these agencies are engaged in a destructive turf war to maintain control over small pieces of the long-term care delivery system regardless of the social or monetary consequences.

Having given our support to Bill 173, though, we feel that the legislation as it is currently drafted falls short or is silent in several critical areas. Tomorrow you will hear from two of our major affiliates, the Canadian Union of Public Employees and the Service Employees International Union, who share our support for the other concerns about Bill 173 that they will bring to your attention. Today I will bring to you our recommendations, but first I want to highlight the following points.

First, the OFL strongly supports the seniors' organizations in their support of Bill 173.

Secondly, the legislation must include the rights of consumers to choose to receive services in their homes, in the community or in long-term care facilities.

Third, the long-term care system must be adequately funded to provide mandated services without user fees, contracting out or excessive waiting lists.

Fourth, MSAs must be limited to purchasing a maximum of 10% of MSA budgets, and these services must be purchased from non-profit agencies.

Fifth, the imminent formation of MSAs in the long-term care sector will mean extensive workforce dislocation. Many health care workers are going to find themselves in low-paying, part-time work or with no job at all. They will be left without adequate qualifications or skills to adapt to the new jobs in the MSAs. Unfortunately, Bill 173 is strangely silent on the entire issue of labour adjustment, workers' rights or human resource planning. There is nothing in the legislation that indicates that existing front-line service providers will form the core staff of the MSAs.

The labour movement has repeatedly called on the government for a provincial, enforceable, comprehensive employment security agreement that would facilitate the redeployment and retraining of workers displaced in the health care sector. This agreement would guarantee workers who are displaced as a result of health care

restructuring the right to comparable employment and retraining. It would establish a protocol to move workers to those parts of the health system which are supposed to be expanding, like multiservice agencies. So we would suggest that Bill 173 must be amended to include employment security and labour adjustment protocol. Wage and benefit parity between front-line workers in institutions and in the community health care sector must be entrenched as our goal. Good working conditions and decent wages and benefits are, we believe, integral to quality health care.

During the forums that the federation held in May and June—these were forums that were held across the province—we repeatedly heard from front-line workers that they no longer enjoy their jobs, that they run and run each day and it's not enough. They go home at the end of a shift feeling guilty because they could not give good quality care. We believe we owe it to our front-line workers, to the people who provide service to the sick and the elderly, to provide them with secure employment, good working conditions and the respect they so deserve.

I would also like to set the record straight on labour's view on volunteers. The labour movement values and understands the role of volunteers. After all, our labour movement has been built on volunteers. However, we strongly oppose the use of volunteers to do work that should be done by full-time trained staff. Volunteers should complement the system, not provide the cornerstone.

We have a long-standing agreement with the United Ways of Canada and the Canadian Labour Congress which has been followed up with local agreements between individual United Ways and local labour councils. In these agreements, we have clearly outlined the role of full-time workers and the role of volunteers, and we believe that Bill 173 must be amended to reflect this perspective.

The Ontario Federation of Labour also calls on the government to amend Bill 173 to allow front-line workers on the boards of MSAs and district health councils. We also feel that MSAs and DHCs must be required in legislation to operate in a spirit of openness.

1640

Finally, I cannot conclude my comments on the long-term care reform system without adding comments on the downsizing of the acute care system.

The downsizing of the acute care system is out of step with the long-term care reform. Since 1989-90, over 7,900 beds have been closed in this province, but the community services have not been put in place to pick up the increased work. Therefore, the OFL calls on the government to stop the closure of hospital beds in the acute care sector until the MSAs are in full operation. Hospitals must ensure that appropriate community care is available before anyone is discharged. We would call upon the government to investigate the rise in readmissions because of premature discharge, the stories of people being sent home to fend for themselves without any support services, and the increased difficulties of being admitted into hospitals for serious illnesses.

Finally, doctors already are by far the best paid, best organized and most secure workers in the health system. We oppose the introduction of any legislation that will allow doctors to incorporate as private businesses. Such a move will cost taxpayers over \$65 million, moneys we can't afford to throw away, moneys that could be well used to increase front-line delivery of long-term care services.

The Ontario Federation of labour is on public record in opposition to doctors' incorporation, and I today call on the standing committee and the people in this room to join the labour movement in ensuring that legislation for doctors' incorporation is not introduced.

I'll just quickly move through our recommendations:

(1) That the purpose of the act be amended to read: "To ensure that a wide range of community services are available to people in their own homes, in other community settings, and in long-term care facilities."

(2) That a clause be added in the bill of rights stating that a person receiving services has a guaranteed right to make the choice of receiving services in the community or in a long-term care facility.

(3) That Bill 173 be amended so it's clearly stated that MSAs will be appropriately funded to ensure they can provide the services they are mandated to deliver without user fees, without contracting out or without excessive waiting lists.

(4) That Bill 173 be amended to ensure that home care program services, currently insured under OHIP, continue to be insured whether provided in the home, other community settings or long-term care facilities.

(5) That means-testing and user fees for long-term care services not be legislated in Bill 173.

(6) That under the section of approval for agencies, the following conditions be added: first, that the MSA will strive to provide 100% of the mandatory services without relying on purchase of service; second, that the MSA will provide secure employment and good working conditions for its employees; and third, that the MSA is required to table, as part of its approval process, a human resources plan.

(7) That subsection 11(3) be deleted. Boards of health and municipalities should be allowed to compete along with other organizations seeking to become designated as MSAs.

(8) That a clause be added under part VIII, section 27, concerning financial accountability. Regular financial reports using accepted accounting procedures such as audited financial statements, balance sheets, income statements and statement of change in financial positions need to be included. A section should also include the financial arrangements made with any purchase of service agreement. All financial reports should include a section on the impact of the financial arrangements on quality of care and quality of work of the employees.

(9) That Bill 173 limit the purchase of services to a maximum of 10% of MSA budgets.

(10) That Bill 173 clearly legislate the preference for non-profit agencies. It should stipulate that where services are available from non-profit agencies, MSAs should

provide such agencies with the opportunity to provide such service prior to purchasing them from a for-profit agency.

(11) That all exceptions to the rules governing maximum limits, clause 13(3)(b) and (c) for the purchase of services should be deleted. These include purchasing services due to short-term absences of employees due to illness, vacation or other unplanned event or from a self-employed individual.

(12) That the current program distinctions in Bill 173 be deleted and replaced with a comprehensive list of mandatory services.

(13) That Bill 173 be amended to include: The Community long-term care sector will be fully staffed by properly trained and qualified employees and supported by appropriate complementary services and programs offered and run by volunteers. Work previously provided by any employees in the health care sector will not be displaced by volunteers and volunteers will not work in positions which provide ongoing service for which funding could and should be made available.

(14) That the Ministry of Health develop a protocol on the role of volunteers in consultation with organized labour.

(15) That a section be added to Bill 173 requiring MSAs to develop a human resources plan that includes a labour adjustment strategy.

(16) That a section be added to Bill 173 which outlines the rights of workers in the system. These rights to be developed in consultation with organized labour.

(17) That the standing committee on social development urge the government to implement a provide-wide comprehensive employment security agreement that provides the framework for a redeployment system that ensures that workers who are displaced by health care restructuring are placed in comparable jobs at comparable pay and benefits in other parts of the health care system.

(18) That a mandatory redeployment protocol be enshrined in Bill 173. The elements of this protocol to include:

(a) front-line service providers who are currently working in community long-term care jobs be guaranteed the right to move to the new MSA with their jobs at no loss of salary or benefits;

(b) that employers be required to register all laid-off workers and post all new positions in vacancies with the central registry;

(c) employers be required to hire from the central registry of laid-off workers; and

(d) workers be provided appropriate training to prevent layoff and to be moved into the new community jobs.

(19) That the health sector training and adjustment panel be mandated in Bill 173 to administer the redeployment protocol and any necessary training to prevent layoff or assist workers with the move to new jobs in the community sector.

(20) That Bill 173 enshrine the goal of equalizing the wages and benefits of front-line workers in community health care with the institution sector.

(21) That the Ministry of Health establish a plan to implement this plan.

(22) That section 17, prohibiting employees at the agency from being a director on an agency, be deleted.

(23) That conflict-of-interest guidelines for all directors of MSAs be included in the regulations.

(24) That the standing committee on social development urge the government to accept labour's position that labour nominate the labour names to DHCs through joint OFL-ONA nominating process.

(25) That Bill 173 be amended to entrench labour's position that labour nominate four labour appointees, two labour consumers, two labour providers on each DHC.

(26) That Bill 173 be amended to ensure that board members of MSAs and DHCs be remunerated for any lost wages and expenses they incur in order to attend meetings.

(27) That section 11 and section 62 be expanded to require that MSAs and DHCs hold open meetings, hear deputations, answer questions about finances, administration and delivery of services, and make all records including financial records available to the public.

(28) That the standing committee on social development urge the Minister of Health to do the following actions:

—Stop the closure of hospital beds until the MSAs are fully functioning and prepared to take the increased work.

—Require the hospitals to ensure that the family physician has been notified that a discharge plan has been approved and that the appropriate care is available in the community before any individual is discharged.

—Investigate immediately the stories about the rise in readmissions due to premature discharges, the stories of people being sent home without any support services in place, and the increased difficulties of getting admitted into hospitals for serious illnesses.

In conclusion, the government must find the resources to appropriately fund the system. If not, Bill 173 will only remain an empty promise and the hopes of many seniors will be shattered. It has been said that a measure of civilization is how it treats its elders and its young. I hope when it's time to reflect on health reform in Ontario that we also use this measure as a way to judge its success. I hope we conclude that we have treated our elderly well and that we have not sacrificed them to the gatekeepers of the health system—the rich and the powerful.

**Mr Jim Wilson:** Thank you, Ms Davis, for your submission to the committee on behalf of the Ontario Federation of Labour. You may be surprised, but I agree with a number of your amendments. I have one overriding question here: With 28 amendments, some of which cut to the core of this bill, how do you support your statement that you're still supportive of this legislation?

If I may make a caveat to that, we've not seen major change by this government after the committee process, so I'm wondering if you know something we don't know.

**Ms Davis:** One always lives in hope that a public consultation is exactly that, and that the reason for the

consultation is to hear what people have to say about the changes they think are necessary. I guess what it comes down to is whether the glass is half full or half empty, and we take the view that the glass would be half full if the bill was to go ahead without these reforms. We would prefer it to be entirely full, but we still think that a step forward is needed in this area.

**Mr Jim Wilson:** Part of the half-full optimism, I gather, is your contention that MSAs and the new administrative structures will save \$90 million. Do you back that up with documentation that you can provide to this committee?

**Ms Adrianna Tetley:** We believe that the Price Waterhouse study that came out—the consumer alliance report they released—and that's where we got our figures. If you don't have it, we could make it available.

**Mr Jim Wilson:** Oh, we have it, thank you very much. We're enjoying looking at it.

**Interjection:** We even have the bootlegged version.

**Mr Jim Wilson:** As I said, some of the stuff we can agree with you on. I have one overriding question though, and I do apologize to the committee and to yourselves, I can't remember the exact union. They said they were the third largest. They were the Christian labour association or union. They presented a couple of weeks ago.

They wanted to know why the government was so hell-bent on its not-for-profit preference because the example they gave—and I'll say at the beginning, I think they were a little wrong on their figures. They said, take for example the not-for-profit nursing home sector, homes for the aged, where the administrator—they said the average was \$136,000-a-year salaries. They compared that to nursing homes where they said—I think they're wrong on the figures—that the administrators there made half as much on average as those in the not-for-profit sector and they were mad that the money the not-for-profit administrator was making, what seemed to be excessive dollars, should be going to front-line services. How do you respond to that even if the figures are a bit skewed?

**Ms Davis:** It may be that the money's not going into the pocket of the administrator in the for-profit nursing home, but I assure you it's going into the pocket of the owner, and our experience has been over many, many years that any time you bring the profit motive into the delivery of care, whether it be for our children in child care or our seniors in nursing homes, the quality of care suffers, and that's something I've worked on personally since 1975. The evidence is overwhelming that you lose in the quality of care when you bring the profit motive into it.

1650

**Mr Jim Wilson:** As you can imagine, we might disagree on that point.

**Ms Davis:** We would be astounded if we didn't.

**Mr Jim Wilson:** I'll leave it at that. Thank you for your presentation.

**The Chair:** Thank you both again very much for coming before the committee this afternoon and for your submission.

## ONTARIO SOCIETY OF OCCUPATIONAL THERAPISTS

**The Chair:** I next call on the representatives from the Ontario Society of Occupational Therapists. Welcome to the committee.

**Ms Christie Brencley:** My name is Christie Brencley and I'm the executive director of the Ontario Society of Occupational Therapists. With me is Janet Gleason, herself an occupational therapist working in long-term care service delivery at the Sunnybrook Health Sciences Centre here in Toronto. Janet chairs the OSOT long-term care task force, and with her is Linda Marshall, who is also an occupational therapist working in the long-term care community-based delivery system with COTA, Community Occupational Therapists and Associates, also here in Toronto.

The Ontario Society of Occupational Therapists is really very pleased to have an opportunity to present to you the views, opinions and recommendations of Ontario occupational therapists. We are the professional association representing occupational therapists in the province, of which you may be aware there are approximately 2,400 registered occupational therapists.

OSOT represents approximately 1,300 OTs, and although it is difficult to gather data on exact numbers because of how our current long-term care delivery system is organized, we are aware that over 400 of our members indicate a focus of their clinical practice to be in the area of long-term care, so this reform initiative is indeed important to OTs, and we bring to you the voices of a significant group of stakeholders in this whole process.

By way of a brief introduction, occupational therapy is a health profession that is concerned with developing skills, restoring function, maintaining ability or preventing disability, promoting health in individuals whose lives have been disrupted, who are experiencing limitations in the areas of self-care, leisure or productivity: A term that OTs use to describe work-related skills whether they be in the office, home or student sector.

OTs treat clients whose lives have been disrupted by a variety of conditions, physical injury or illness, congenital or developmental limitations, the aging process, mental illness and/or social or emotional problems, and clients are treated across a lifespan from the neonate to the frail elderly. It is a client-centred and holistic practice that strives to maximize a client's ability to function independently within their unique environment.

I think perhaps a unique perspective that an occupational therapist brings to the long-term care intervention is an analysis and application of functional and goal-directed activity as a therapeutic medium to prevent or remediate disfunction, as well as the holistic concern and attention to the development of the functional ability important to the individual to meet their daily living needs.

I will let you speak to our long-term care expert at the moment.

**Ms Linda Marshall:** Having worked in the community for 15 years as an occupational therapist, I come with a community perspective. OTs are particularly interested

in the reform of long-term care because of their extensive experience in this area. Presently, occupational therapists are either employed by home care or, as in Metro Toronto, are separate from and contracted by home care, to provide occupational therapy services.

In the present system of home care, a medical referral from a doctor is required. As well, service providers are required to provide a minimum number of visits, despite individual client needs. We're very pleased that the present government is planning to eliminate some of the criteria that, in fact, we see as hampering service provision, including medical referrals and a minimum visiting number.

The Ontario Society of Occupational Therapists supports the basic principles and goals of long-term care reform and its client-centred approach. We also support the five main objectives: one-stop access, an improved community-based system, a consumer focus, improved and consistent accountability, and local, community-controlled planning through district health councils.

Occupational therapists recognize inadequacies in the current system of service delivery: inequitable access, prolonged waiting lists for service, lack of coordination of care plans and services, and inefficient use of public funds. We believe the MSA model will simplify and enhance consumer access to long-term care service in Ontario. However, we do identify a number of concerns related to this model as defined in Bill 173. I'll ask Janet to outline those concerns.

**Ms Janet Gleason:** OSOT identifies the following concerns and recommendations for your review and consideration. We have identified issues which we believe will put the model at risk and urge the committee to take action to address these points. I'll be reading from our response, and if you'd like to follow along, I'm starting from the last paragraph on page 4 of our submission.

Occupational therapy delivery in the multiservice agency; occupational therapy as a core professional service: It is appropriate and important that occupational therapy be included as one of the core professional services. Occupational therapists are regulated and, as previously mentioned, provide a holistic, functional and client-centred approach to assessment, treatment and interventions. Occupational therapists also include education and wellness promotion as part of their treatment. This approach fits well with the government's long-term care reform.

Provision of occupational therapy services: It is OSOT's position that occupational therapy services must be either directly delivered by an occupational therapist or delivered by support personnel who are directly supervised by a registered occupational therapist. OSOT is concerned that Bill 173 does not provide assurance to the consumer that occupational therapy services will be provided by a qualified occupational therapist. The concept that someone else other than an occupational therapist could be responsible for delivering or directing occupational therapy services is not acceptable. In such a case, there would be little accountability to the public, nor the ability to ensure quality occupational therapy services.

In Bill 173, in the compendium, on page 18, it is stated that:

"The act does not specify what professional or trained non-professional must be employed to provide a certain service. This will permit alternative, lower-cost workers to provide services if the task or procedure is not restricted to a specific scope of practice under the Regulated Health Professions Act."

We are very concerned that lower-cost staff will be used by the MSAs for all services except those requiring professionals as stipulated under the Regulated Health Professions Act. This means potentially, that para-professionals would provide services best provided by occupational therapists. We do not believe this is in the public's best interest.

OSOT recommends that the bill be amended to clarify that professional services should be provided by registered members of the regulated professions.

#### 1700

Need for access to specialized services: OSOT is concerned that all the rehabilitation needs of MSA clients must be addressed. Because of the complexity and the unique needs of many long-term care clients, demands on MSA occupational therapy staff will be significant. It should be noted that within the profession clinical experience lends to the development of expertise. For example, occupational therapists working with large numbers of seating clients develop unique skills in this area.

In order to capture appropriate expertise for all clients without the expectation that the MSA staff provide all specialty services, OSOT recommends a blend of both onsite occupational therapists located within each MSA as well as access to external specialized services. Services such as orthotics, prosthetics and wheelchair seating may be more cost-effective if they are out-sourced from agencies outside the multiservice agency.

These services often require an extensive inventory of both equipment and tools, and it would be quite costly to maintain such inventories, especially in remote areas where the services are required. Access to such specialized services would be a practical solution that would enable a more universal accessibility. It should be noted, however, that this solution may have serious consequences on the 20% external funding cap.

Cost-effectiveness: Occupational therapy services can be extremely cost-effective in the long run. An example is the following: A woman who returns to her home following a stroke is unable to make her own meals. She is referred to the MSA and could be referred to either an occupational therapist or a homemaker. It would be more appropriate to refer this woman to an occupational therapist who would help the client develop the skills that would ensure that she reached her maximum level of functioning. If she received homemaking only, it is conceivable that she would not regain or develop the skills necessary for her to be independent and that she would then require homemaking on an ongoing basis.

Alternatively, if an occupational therapist provided the service, the woman, for example, would be taught energy

conservation techniques, adaptive strategies for meal preparation and safe use of kitchen appliances with the intent of eventual discharge from the program. Although in the short run this might be a costlier approach, in the long run it would provide the client with an improved quality of life and reduce costs to the program.

Other areas or roles for occupational therapists within the multiservice agencies: Occupational therapists have expertise to contribute to the multiservice agencies in addition to direct-patient care. Some examples are planning service development, advocating for individual clients or a group of clients, public education and health promotion activities. Occupational therapy assessments focused on function and life skills performance will be critical components in the identification of support services required for clients.

Evaluation and professional standards: Currently, the proposed act does not describe a mechanism for the maintenance of professional standards and supervision of professionals and support personnel. As the MSA assumes the role of employer, provisions must be in place for the assurance of potential for professional service development, professional education etc. Evaluation models to study the effectiveness of all the MSA services should also be defined.

Out-sourcing of professional services: OSOT is concerned that the limited proposal for out-sourcing of professional services is restrictive and shortsighted. Bill 173 proposes a cap of 20% on the out-sourcing of professional services, thereby requiring the vast majority of services to be provided within the MSA itself.

OSOT proposes a more flexible approach to accessing external services with a requirement that the procurement of external services be closely monitored and evaluated in order to assure the cost-effective use of funds and provision of service excellence. We make this recommendation for the following reasons.

As previously described, occupational therapy and rehabilitation services for long-term care clients are diversified in nature and focus, often requiring professional expertise, specialized equipment and resources etc, to meet individual client needs. The requirement that services be provided internal to the MSA requires that the MSAs secure the appropriate professional and equipment resources to meet all the specialized rehab needs for their clients. We believe this could be an unrealistic target for many areas and very costly to the service agency.

This would be particularly true in rural or outlying agencies where it may be difficult to access enough therapists with diversified specialized expertise. Furthermore, the client population may not require the specialized services at a frequency consistent enough to staff for them. We reiterate that these types of services may be most efficiently accessed outside the MSA.

It is unacceptable that clients experience delays in accessing long-term care services due to the cap on out-sourcing of services. Rehabilitation interventions are only effective if they are timely, and effective rehabilitation is cost-effective by reducing the client's long-term requirement for hospitalization and support services.

There exists a critical shortage of occupational therapists to meet the needs for services in Ontario. This is noted particularly in northern and rural parts of the province. A more flexible approach to accessing external services would promote maximal usage of limited resources.

OSOT is not convinced that limiting access to a for-profit market is cost-effective. On the contrary, we would argue that providing for participation of the for-profit sector in this system would introduce a constructive competition into the marketplace which may ultimately facilitate cost-efficiency. We further promote that participation of this sector may provide a continuing catalyst for service delivery development and increasing quality of service. A system working in isolation of competition has more potential to become stagnant, inefficient and complacent.

OSOT suggests that this issue be thoroughly reviewed. Related to this is the impact the bill will have on outreach services currently provided by existing health care institutions and specialized community-based programs.

Bill of rights: The proposed bill of rights in part III is a concept occupational therapists can support philosophically and ethically. We believe in its intent. However, OSOT is concerned that by capturing such a code in legislation MSAs can be held to fulfil the literal interpretation of the bill. This we believe could be quite costly and in some cases impossible. For example, will consumers come to expect that all services should be delivered in their language of choice or with input from professionals who share their cultural background?

OSOT proposes that the bill of rights be modified to reflect the intent but with provisions for "reasonableness." The bill of rights could provide for assurances to regions that have particular cultural characteristics where a density of population makes a demand for services reasonable.

Case coordination: OSOT advocates that mechanisms around coordination of cases be clearly defined to avoid what is often the single most troublesome aspect of interdisciplinary or multidisciplinary care for the consumer and the service provider: the lack of or poorly coordinated care.

The bill outlines how a plan of service is to be developed, but it remains unclear as to who has the final say regarding the services provided to a particular client. What exactly is the client's role and decision-making power in this process? Who sits on the Health Services Appeal Board?

OSOT recommends that program planning and coordination is most effectively managed when a case coordinator is established who is responsible for consulting with involved service providers, the client and other components of the system. Occupational therapists have skills that lend well to this role.

The regional geriatric program currently exists and offers a model for consideration. An assessment team of two or three persons visits and meets with the client and makes recommendations regarding which are the most

appropriate services for the client. The team is responsible for assessing the client and then forwarding the case to the appropriate services. This system facilitates team discussion to best determine the best services for the client.

**The voluntary sector:** The voluntary sector provides a valuable array of services to the community long-term care sector of the population. OSOT believes this is an important component of community-based care, not only because of the financial benefits but also because of the community and social responsibility it brings to life. Measures to protect voluntarism are important so as not to diminish these services through the transition period or through union restrictions with making services that were traditionally provided by volunteers—and an example would be friendly visiting—mandatory.

1710

In conclusion, OSOT supports the thrust of the legislative changes proposed. Our holistic, functional, client-centred practice corresponds well to the reform strategies presented. Our presentation hopefully includes constructive feedback which we hope will be of assistance.

In summary, we believe that the following can ensure that Bill 173 will more effectively achieve its targets of reform:

- The provision of occupational therapy should be provided by a registered occupational therapist.

- More flexible access to professional services and special services outside the MSA.

- Clear mechanisms for case coordination within the MSA.

- Modification of the bill of rights to ensure it can be implemented.

- The development of evaluation mechanisms to test service delivery efficiency and effectiveness.

- Protection of the voluntary sector in the long-term care sector.

**Ms Carter:** Thank you for your presentation. I certainly welcome your general support for the bill.

I note that occupational therapists are listed under professionals in the bill, as far as that goes. I understand that the 20% purchase rule doesn't apply to individual practitioners or various professionals. Is that correct?

**Mr Wessinger:** Yes, that is correct. It doesn't apply to purchase from an individual who provides professional service or any other type of service.

**Ms Carter:** So in so far as you're independent practitioners, that proviso won't affect the freedom with which an MSA would employ you. Is that how you had seen it, or were you not aware of that point?

**Ms Marshall:** I think we certainly see, the way the MSA structure is set at the moment, that occupational therapists would be employed within the MSA. One of our concerns is the variety of occupational therapists that we have. Occupational therapists specialize and usually go into one of two streams, either into psychiatry or physical medicine, and within each of those streams there are a lot of subspecialties. We're having difficulty conceptualizing how all of these specialties could be

employed in an MSA, how an MSA could afford to employ all these specialties' or whether the specialists, since there's a small pool of them, would be better to be outside the MSA and providing consultations. It's not that we feel that OTs can't be employed by MSAs; it's just the complexity of it.

**Ms Carter:** But if there were several MSAs, maybe in a heavily populated area, then they would certainly be able to draw on the same pool of different types of specialists, wouldn't they? Whereas I imagine in a remote community they would probably have to employ somebody who would have to cover that range.

**Ms Marshall:** Yes.

**Ms Carter:** We had a previous presentation—I'm not sure whether you were here for it—where the question of volunteers was raised in a rather novel way. I think we all accept that volunteers are highly essential and that we want to keep them. Obviously the system is so heavily dependent on volunteers, it couldn't run without them. The Price Waterhouse report certainly states that fears that voluntarism will be undermined are unfounded, because there will be a great deal of local participation in the development of MSAs and that will obviously involve a lot of grassroots input. Existing multiservice agencies have been very successful in maintaining volunteer loyalty.

But what I wondered was, do you have any feelings about the range of activities that volunteers should be able to provide? Do you feel there should be any limitations on that?

**Ms Gleason:** I think what we were thinking of is things like friendly visiting, what is normally being done right now with the voluntary sector. I guess we're hoping that with legislation and making this mandatory there won't be union restrictions etc which make it so that it's now a cost factor.

**Ms Brenchley:** The other point that we would like to raise is a philosophical point, and that's simply that involvement of a voluntary sector in health service delivery is an important social concept which we would embrace and would hate to see destroyed in any way because it embodies the sense of commitment that as a community, or as a province or a region, all participants in the community bring to the service delivery model. Long-term care, being as embracing as we perceive it to be, and likely to grow in terms of its client population as our general population ages, is one where we feel the voluntary sector can contribute very constructively, and gain itself as well.

**Ms Carter:** You also raised the question of how quality will be maintained in the absence of competition. We had another presentation today which suggested that multiservice agencies should compete with each other, that maybe they would have different focuses—for example, ethnic background or specialization in certain types of treatment—and that people will be able to go to the one that they thought would best suit their needs. I just wondered if you had any reaction to that sort of concept.

**Ms Marshall:** My reaction to it is wondering about

the logistics of it and MSAs getting a certain amount of funding, and if a lot of people in one MSA area want to go to the other MSA, what the cost questions are for the MSAs. If you're getting a lot of people from various surrounding areas coming to a different MSA, that must be a real cost factor for the MSA that they're changing to or going to, I would think.

**Ms Carter:** The suggestion was the total funding would be set within a given region. I guess the more competitive MSAs would get a bigger share of it because they get more of the patients.

**Ms Marshall:** I philosophically don't have any problem with individuals going from one MSA to another. I think it should be a fairly fluid boundary, that people can have some decision-making power themselves about where they can best get services.<sup>172</sup>

**Ms Gleason:** My only concern with that would be with the outlying areas where the geographical distance between MSAs would make competition even more difficult.

**Ms Carter:** It would only be possible in densely populated areas, obviously; in a rural area you couldn't do that.

**Ms Marshall:** Even in a densely populated area, the clients who would be seen in an MSA, a lot of them would be far too—I was going to say impaired—to be able to—if it meant travelling, but I don't know whether you're envisioning travelling.

**Ms Carter:** No, I don't think so.

**Ms Marshall:** Envisioning the MSA travelling to them.

**Ms Gleason:** Also, that could become even more costly, if the MSA services would have to move from one area to another; for example, an occupational therapist from one MSA goes right across the town to service someone, in so far as a lot of the clients whom long-term care serves aren't able to get to the services themselves.

**Ms Carter:** Maybe that would work in Toronto, but nowhere else.

**Ms Gleason:** Possibly, yes.

**The Chair:** Thank you very much on behalf of the committee. We still have a couple of presentations and I know the clock is ticking away, but we do want to thank you very much for coming before the committee this afternoon.

1720

CANADIAN RED CROSS SOCIETY,  
ONTARIO DIVISION  
DISTRICT OF MUSKOKA BRANCH

**The Chair:** I ask for the representatives from the Canadian Red Cross Society, district of Muskoka branch. I want to welcome you to the committee. I can only assume you have come from where the colour is magnificent and where we should all be sitting, but maybe we'll get there this weekend. Welcome to the committee.

**Ms Barbara Gibbs:** My name is Barbara Gibbs and I am manager of the Red Cross homemaker program in Muskoka. Norma Bustard, who was going to present today as a senior citizen member of our advisory commit-

tee, is ill. In her place is Lynn Moore, who is the director of home support services for Ontario division.

**Ms Lynn Moore:** I was honoured that Norma trusted me enough to give me her notes to present to the committee.

Homemaker services began in the Muskoka district in the late 1970s with eight homemakers and has grown to the point of employing 140 homemakers today. The service is valued by the community, and particularly by those who are able to receive care in their homes, rather than be institutionalized.

The role of the homemaker has evolved from that of the house maid to a well-trained member of the community health team. Through an ongoing educational program and on-the-job training, our present homemakers are prepared to provide personal support services as well as basic housekeeping activities. The homemakers' increased responsibilities allow us to make the most use of limited funds allocated to community-based health care.

The Red Cross Society supports the efforts to proceed with long-term care reform. While we strongly approve of the principles and goals outlined in Partnerships in Long-Term Care—they were, after all, decided on after many hours of consultation with key stakeholders—however, there are still some recommendations in Bill 173 that we cannot accept.

The current draft of the legislation and the movement to create multiservice agencies will exclude us, the Red Cross, from providing long-term care services because the Red Cross is federally incorporated and because our fundamental principles of independence and unity would be compromised.

Norma has specifically asked that I highlight three of the society's fundamental principles: independence, which means that we must be able to maintain autonomy of governance to act within the principles of the Red Cross and Red Cross movement; voluntary service; and unity, which is important to permit the society to carry on its humanitarian efforts throughout its territory, which in this case is Canada.

From years of experience, community-based organizations such as the Red Cross homemaker service with local boards have a successful record of accomplishments in the delivery of services in the health care field. It is difficult to understand why the government would initiate changes to the system which, in an attempt to centralize services, would simply establish a system that would stifle our deliverance of satisfactory long-term care.

The Red Cross homemaker service wants to continue giving long-term care to the residents of Muskoka district. If you look at Muskoka carefully, you will see a service already achieving many principles on which Bill 173 was based: accessibility, decreased fragmentation, consumer orientation and cost-effectiveness.

The Canadian Red Cross program has had in place for the past four years a 1-800 number for easy accessibility from all points in the Muskoka region. When receiving a call from a consumer requesting our services, our supervisors work very closely with that person to make sure that we can best meet the needs of that client for the least

cost to them, for example, reviewing the number of hours of services needed, piggybacking this service on to another activity or directing the client to a cleaning service, if that is more appropriate and if that service is indicated.

We are in a very unique position in Muskoka, because there is only one homemaking agency—the Red Cross. Nursing and professional services are delivered by the home care program and, due to areas of the municipality not receiving services, only two home support programs exist in localized settings. Services are not fragmented and the few service providers coordinate services—

*An emergency alarm sounded.*

**The Chair:** It's okay; that's "advised." It's my office, I think.

Please go ahead. There may be another bulletin as we go along, but we won't leave you and you won't have to leave us unless there's the demand that we get out of here. So please go ahead.

**Ms Moore:** Services are not fragmented and the few service providers coordinate services very well. The Muskoka-East Parry Sound home care program case managers work very hard to provide services to all clients. For those not currently covered under their program mandates, calls are often made to appropriate agencies for assistance on behalf of the client, rather than the client themselves having to hunt around, getting lost in the cracks or giving up hope.

To become more cost-effective and also ensure that the consumer gets quality care, the agencies throughout our area have developed joint level 2 and level 3 home support training programs for homemakers under the leadership of the Red Cross homemaker program.

*An emergency alarm sounded.*

**The Chair:** I apologize for this, but at least we know that here we're safe. Please go ahead, and if we have to leave, we will do as directed. Please continue with your presentation.

**Ms Moore:** Red Cross is recognized by clients, home care and other providers for its high calibre of service provision. This is because the agency has been proactive provincially in setting standards of service delivery, and this is the agency which is recognized by other service agencies as having a meaningful quality management program. We are definitely consumer-responsive because this will ensure that all consumers receive the same high-quality standard of care. Customer satisfaction surveys conducted by home care attest to the high level of satisfaction of consumers.

*An emergency alarm sounded.*

**The Chair:** Again, my apologies. Please go ahead. My only concern is that's where my office is. I don't know what I've got left.

**Ms Moore:** I must say, I can't help but wonder, since this is the eighth time the Red Cross has presented, if there's not a message here.

**The Chair:** Please don't take it personally.

**Mr Jackson:** There's nobody I'd rather be with in the middle of a fire. I want you to know that.

**Ms Moore:** I haven't had my first aid training yet.

As a result of long-term care reform, other positive steps are being taken to improve service and to reduce costs in our area. A cooperative purchasing consortium of agencies was developed to increase volume purchases and therefore to decrease the cost of office supplies. Equipment and training resources are shared between agencies in order to reach the largest number of people at the least cost to the agency. Therefore, in Muskoka we are accomplishing much already that other areas are still struggling towards, which, I must add, is not reflected in the Price Waterhouse report.

The legislation must be flexible enough to meet the rapid changes in long-term care. This would allow the service providers to meet the changing needs of their diverse communities. It must encourage all people in providing community-based long-term care to strive for fair and genuine collaboration to efficiently provide this service to the community. We are insistent that the system must not fail the vulnerable who depend on these services. We are proud of the steps we have taken to meet these service demands.

I would just like to add that as someone who has worked in long-term care for many years, I think the role of voluntarism is essential to our system. Staff may be very caring, but they are paid staff. Volunteers are there because they care and they want to be there.

**Ms Gibbs:** As I said, I am Barbara Gibbs and I manage the homemaker program in Muskoka branch. We provide services to Muskoka and we are beginning to provide home support services in the Honey Harbour-Port Severn area, where it was recognized that gaps in service existed.

Where other agencies provide homemaking and home support services, we work very closely to ensure coordination for clients. As you have heard, there are actually few service providers in our area, so we do not have the problem of fragmentation.

To give you an idea of the size of our homemaker operation in Muskoka, we will provide 144,000 hours of service to 1,600 clients this year. More than 61,000 home visits will be made by well-trained, uniformed Red Cross homemakers to citizens of our communities. These visits will enable clients to recover at home, to live with dignity in their homes and communities or, if they choose, to die at home within familiar surroundings and with the support of loved ones.

1730

In the last three years, our service has expanded by 110%, with an increase in the number of consumers, complex care clients and the introduction of the integrated homemaker program. I believe this growth would have been extremely difficult, if not impossible, to cope with without the experience and support of the volunteer committee members and the huge, province-wide infrastructure that exists with Red Cross.

As a manager and a lifelong citizen of the Muskoka region, I take great pride in providing quality service which does respond to individual client needs. Our customer satisfaction surveys, sent to all clients after

service completion, which can be anonymous if the client chooses, indicate a high level of satisfaction, and I might add that our local home care program, independent from Red Cross, conducted its own client satisfaction surveys on our service which confirmed that high level of satisfaction.

As a manager, I know how important it is to provide services at a price that taxpayers can afford—

*An emergency alarm sounded.*

**The Chair:** Good. We're safe, so we can continue.

**Ms Gibbs:** This is working under stress—and I have to tell you that I was greatly dismayed when I read the Price Waterhouse study, which says our administrative costs are almost 30%. In actual fact, our administrative costs are just under 11%, and this is the norm for Red Cross programs throughout Ontario.

Even with this low overhead, we have been able to develop many programs which have moved the entire homemaker industry forward; for example, our quality management program, our Homemaker Handbook, which is a policy procedure guide given to each of the almost 6,000 homemakers—

*An emergency alarm sounded.*

**Ms Gibbs:** —and an automated accounting and scheduling system, to name a few. We in Muskoka now provide service with professional backup 24 hours a day, seven days a week, as do all Red Cross branches across Ontario.

I challenge some of the comments in the recent report of the senior citizens' alliance which appeals to ordinary citizens, consumers and taxpayers to prevent the short-term interests of providers and politicians from undermining the viability of our publicly funded, long-term care systems. This report suggests we are self-serving and are fighting to retain the current system because we fear change.

We, like members of the alliance, want seamless, coordinated care, to have easier access to the system. We have not resisted change—in fact have advocated for change for years. We have seen inefficiencies in the system and have worked very hard to correct them. While the system has benefited from our initiatives over the past years, much still needs to be done and we are actively participating in making the system even better. Remember, providers are taxpayers too and many of our volunteers and staff have spouses, parents or other loved ones who have been clients or they themselves have been clients.

Our interest is the present and future wellbeing of the clients we were and the communities in which we live and work. I know my community well and I know that organizations like Red Cross, with a long history of service to the community, have earned the trust of the citizens and have become a part of the fabric of the community. I believe it would be careless to assume that a new agency would attract the same number of volunteers and the same level of donations. Despite the negative press we have all heard and seen lately, our organization attracts dedicated volunteers and staff who are greatly loyal to the Red Cross.

For example, homemakers and management staff fundraised on their own time to send dollars to places in the world where citizens are not so fortunate. That money is also used for additional training to build on their already excellent skills. I must say, that fund-raising is running bingos from 10:30 on a Saturday night till 1:30 on a Sunday morning, and that's done by the homemakers and staff, so it isn't that they're doing it easily.

We also have taken money and donated to other organizations to provide respite for family care givers. We are very proud of this kind of commitment. I believe it stems from a belief in the basic principles and mission statement that this humanitarian, volunteer-based organization is built on an identity to a caring organization firmly established in the community. I am not convinced that the new system as is presently described will be more cost-effective; in fact, quite the contrary. I think it will eventually offer less service and will be less able to respond to the changing needs of the client.

I hope that in some ways I have presented a good news story. In Muskoka we do not have fragmented service. We have already instituted efficiencies and there is a will to develop a model which builds on the strength of the current system. I urge you to amend the legislation to allow this to happen.

**The Chair:** Thank you very much. I'm sure this has been the most dramatic presentation that we've had before the committee, and I want to commend you both on being able to get through it with all the racket that's going on. I'm not quite sure why the siren is still going, but presumably it will end at some point.

**Mr Jackson:** Only the fire department can turn it off.

**The Chair:** Okay, that's why. We'll move then to Mrs O'Neill, who is ready with her questions.

**Mrs O'Neill:** Thank you so much for coming. I think I have heard almost all of the presentations from Red Cross and I've certainly met with Red Cross groups as well.

I am very pleased that you have shown that you do want to coordinate and you've proved that in your brief, your 1-800 number and the other things that you have mentioned in your own area. I guess my first question to you is, could you ever have envisaged that this would happen, that Red Cross and homemaking would be threatened through a government bill?

**Ms Gibbs:** No, I did not. Actually, I joined the Red Cross three and a half years ago. I worked as a nursing supervisor in the hospital at that time and my husband urged me not to change jobs, and I said: "But the Red Cross will be here for ever. It's a safe organization and they have provided care for so long that there's no threat leaving a hospital and going to the Red Cross." So no, I did not envision something like this would happen.

**Mrs O'Neill:** I don't think anybody did. I think you're seeing, as am I, that many people are joining with you now that they realize the jeopardy you're in and indeed maybe they are in.

I'm very pleased that you brought your administrative costs forward. We have had one other group bring theirs

forward, and I think theirs was somewhere in the neighbourhood of 7%. It may be a smaller organization than yours, I'm not sure. You say this is characteristic of most of the Red Cross units across the province. Would you be able to provide that in writing to this committee? I think that would be very helpful if you have that data available.

**Ms Moore:** I certainly would be pleased to do that. As you may be aware, there is a press conference tomorrow at which the three organizations named in the study are going to be addressing the misinformation contained in the report.

I must just express my concern that the numbers themselves can be presented very misleadingly. In the report, part of what they classified as administrative cost that could be shared when we move into an MSA structure was the cost of vacation pay to the homemakers, and I would just like to report that I was speaking to 140 homemakers on Saturday, and they clarified with me that no, they would not be willing to give up 70% of their vacation pay to move to an MSA.

**Mrs O'Neill:** I think those are the kind of details that we need.

**Ms Moore:** I'll get that to you.

**Mrs O'Neill:** Certainly the Red Cross has been very helpful in describing why it can't be a member of an MSA. I don't think anybody could have ever believed that could happen.

**Ms Moore:** I joined the Red Cross on the day that the legislation received first reading. I was surprised.

**The Chair:** The sirens continue, but we remain safe here. I want to wish you a quieter, calmer return to Muskoka this evening than the welcome we've had for you here at this committee, but thank you both again for coming and for your presentation.

1740

SHARON GILLESPIE

**The Chair:** I call on our final presenter for today, Miss Sharon Gillespie. We welcome you to the committee and we want to thank you for your presentation. I was just interested in flipping through, and committee members may be as well. This morning for the first time, certainly for me and I think for everyone, we learned about the On Lok Senior Health Services, and then I see you have quite a section on that. So some of these things are beginning to fall into place. In any event, welcome to the committee and please go ahead with your presentation.

**Ms Sharon Gillespie:** Thank you. I may be a little different in that I prefer to work in the private sector retirement industry in medium to small facilities in the hope that they will be prepared for some sort of role in serving seniors in the long-term care system. In this presentation I'd merely like to read the cover sheet, but initially explain the contents of this presentation.

Behind the blue page entitled "The Present?" there is a chart outlining the progress that the retirement industry will probably take to develop ultimately a support services model. I prepared this chart. Only retirement home developers that understand me do it. I don't want you to believe that they (a) understand it or (b) are

performing it in any large scale at this present time, but the desire is there.

In the second section, the reason I've put "The Past?" with question mark is that there are three abstracts there: one discussing the On Lok model as it originated; a replication in a rural setting, which is the Wyoming project; and replication in an urban setting, which is in Colorado. I think many of the things that have been discussed today are reflected there when you speak of consolidated case management.

The reason I put a question mark is that in a geometrically growing problem and without discussion of the exponential function, I just don't know how that model can fully be expressed.

In "The Future?" there are two abstracts from Sweden which, if you look at the stats—and I have put a little excerpt there on how to translate the currency to American dollars—much of what has been discussed in background information to district health councils and other agencies reveals what is already happening in Sweden, and in many respects they are our future.

So, based on a discussion of that content, I'd just like to return to the first page and read this to you.

In this presentation, my goal is to present my views on the content and intent of Bill 173.

Content: darts and laurels.

Laurels: The service to client is well protected and designed to deliver a professional standard. This can only result in better personal service planning and the prevention of abuse through ignorance and lack of training.

Darts: Client access to services could be misunderstood. What is meant by "assisting" a person or "training" a person? Will clients ask to be assessed for services that may or may not exist according to their definitions or current practice? Will clients make life-changing decisions on insufficient/incomplete information, eg, their habitat?

Just to explain that, clients in the private sector now who may be experiencing—we've just listened to the ladies from Muskoka—a room rate of \$48 per day plus services plus food cannot duplicate that in a hotel or anywhere else for that amount. Just the meals and the room alone would cost much more than \$48 a day. Currently, Bill 120 has opened the door for us to duplicate the care delivery practices of the public sector through case management, formal and informal, which could bring down care to merely a visitation experience and leave many people with only a room and only food. The door has been opened for this event to occur, although I hope no one walks through it.

When people are asked to be assessed by patient coordination services and they're told, "Yes, you can have X hours of home care," will it be explained to them how this will be delivered? Will it be explained to them how this is expressed over a 24-hour period? Will it be explained to them how a life-changing decision regarding buying or selling a property when they cannot recover those funds will affect the rest of their lives?

Intent: darts and laurels.

Laurels: Management by results has met management

by objectives head-on. Management by results, of course, is how the provincial government functions, and the Ministry of Health and its providers tend to be dealing with management by objectives. The focus on ability, where quality management must be more than a quality assurance program; accountability, where cost-effective fund transfer patterns will open public-private liaisons for service provision; accessibility, where MSAs streamline service delivery. Nothing could be more excellent than this event.

After-care safe homes—very creative private-public sector partnerships have occurred in Sweden and are outlined in those abstracts.

**Darts:** With rehabilitation, prevention, respite omitted from the list of services you end up with a lean, mean medical model. It does not encourage progress into the vision of a support services model. Where is community development? Where is the empowered client? Apart from any discussions or current theories on long-term care, when you look at the content of this bill, it screams, "We are going to do the medical model the cheapest way possible." It doesn't talk about any progress into what you might term as the psychosocial model or the social programs model; it merely looks like a very efficient budget-saving measure.

Just as an addendum to that, I'd like to speak to you as politicians. The most powerful person you know at this present time in Ontario is a female 60 years old. By the time she's 70, for a five-year period she'll be the voting strength in this country. By the time she's 75, the health care crisis will be upon you. If I was a female 60 years old at this present time, I'd be very encouraged by special pension programs related to an early retirement in this hectic world, I'm sure. It's just a thought for you to consider.

The remainder of this document is meant for you to review, food for thought as you finalize this bill.

**Mr Jackson:** I appreciate very much your brief, and you've shared with the committee a considerable amount of external resources for us to consider. However, I want to go to your main thesis that you laid out very carefully for us. First of all, let me ask you if you're aware of those provinces which have undertaken reform of their long-term care and used more of a support services model.

Generally, it's come through moving medical services into the Community and Social Services panel and Comsoc being the lead ministry. Ontario has chosen, for whatever reason, to bring it through the medical or

Health ministry models. I've been receiving some feedback about the distinctive look, or the potential outcomes would be different when it's taken one track over the other. I think that's part of the point you're making here.

**Ms Gillespie:** It's pretty hard to have a shotgun wedding of two groups of people, one that makes \$17 an hour and the other that makes \$17,000 a year. That can only end in annulment, which it has.

**Mr Jackson:** So what you're suggesting here is that the resources of the two ministries are configured differently and are approached differently, or what am I to interpret from that statement?

**Ms Gillespie:** Too much for them to realistically get along.

**Mr Jackson:** True, and across Canada we've seen lead ministries, but depending on which ministry takes the lead, you get a differing approach. One of the concerns I had was that although we're told the ministry responsible for disability issues, the Ministry of Transportation and the ministry of Comsoc are supposed to be involved in this process, we're seeing precious little of their ministries' influences in the development of this legislation and in fact responses to these public hearings when we raise questions. It has been predominantly a medical model.

**Ms Gillespie:** With transportation discussions being slated for 1995 and somewhat on hold, I can see why you wouldn't perhaps have a lot of input, because there hasn't been a lot of inclusion. But I have great respect for the Ministry of Community and Social Services. I have great respect for all the meetings I've had, many of them spearheaded by Mr Beer, on 24-hour, residential, on-site, off-site, caring for the elderly, services, and when you look at the thread of thought which is followed regardless of who entitles it, it's a social services incentive and thrust.

Perhaps the sophistication of the Ministry of Health is through long-term administrative excellence, whereas in the social services field even learning about administration is only about 30 years old. So I think the sophistication, certainly in this project, are the Ministry of Health.

**The Chair:** Thank you again. I notice the peace and quiet that has descended on the building since you began your presentation, but we appreciate your coming here and for the material you've provided us with today.

The committee now stands adjourned until 9 o'clock tomorrow morning.

*The committee adjourned at 1752.*





## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

\***Chair / Président:** Beer, Charles (York-Mackenzie L)

**Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

\***Acting Chair / Président suppléant:** McGuinty, Dalton (Ottawa South/-Sud L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

\*Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Malkowski, Gary (York East/-Est ND) for Mr Hope

Marchese, Rosario (Fort York ND) for Mr Hope

Mills, Gordon (Durham East/-Est ND) for Mr Martin

Sullivan, Barbara (Halton Centre L) for Mr Eddy

Wessenger, Paul (Simcoe Centre ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

Jackson, Cameron (Burlington South/-Sud PC)

Ministry of Health:

Wessenger, Paul, parliamentary assistant to the minister

Quirt, Geoff, acting executive director, long-term care division

Czucar, Gail, legal counsel

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Boucher, Joanne, research officer, Legislative Research Service

Gardner, Dr Bob, assistant director, Legislative Research Service

# CONTENTS

Monday 3 October 1994

<b>Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,</b>	
projet de loi 173, <i>Mme Grier</i> .....	S-2255
Royal Canadian Legion, Ontario Command .....	S-2255
Jack Currie, chairman, veterans' services committee	
Health Sector Training and Adjustment Program .....	S-2257
Shelley Acheson, chair	
Sue Colley, executive director	
Ken Waterman .....	S-2260
Don Mills Foundation for Senior Citizens .....	S-2262
Roy Arendse, board member	
Catherine Brookman, vice-president, community services	
Carmel Smith, client	
Ontario Community Support Association, Areas 5 and 6 .....	S-2266
David Wartman, president	
Dan Stapleton, executive director	
Community Agencies in Partnership .....	S-2268
Sandra Sillcox, chairman	
Jackie Catto, president, VON, York region branch	
Deborah Egan, executive director, CHATS	
Susan Taylor, regional municipality of York, community services department	
Ontario Nurses' Association .....	S-2271
Jane Cornelius, vice-president	
Carol Helmstadter, government relations officer	
Carol Kushner; Michael Rachlis .....	S-2274
Victorian Order of Nurses, Brant-Norfolk-Haldimand branch .....	S-2278
Don Townsend, president	
Cathy Chisholm, executive director	
Canadian Co-operative Association, Ontario Region .....	S-2280
Kathy Bardswick, council chair	
Judy Goldie, manager	
Trans-Action Coalition .....	S-2283
Janice Tait, project coordinator	
Ontario Association of Residents' Councils .....	S-2285
Peter Kehoe, president	
Mary Ellen Glover, executive director	
Bernard Betel Centre for Creative Living .....	S-2288
Sheila Zane, coordinator, social action committee	
Reta Duenisch-Turner, member, social action committee	
Sharon Zeiler, director, La'Briyut Wellness Centres	
Families' Association of Oaklands Regional Centre .....	S-2291
Catherine Rhodes, representative	
College of Dental Hygienists of Ontario .....	S-2293
Lynda Mckeown-Mickelson, president	
Don Page, vice-president	
Donna Bowes, chair, quality assurance committee	
Ontario Association of Professional Social Workers .....	S-2296
Dan Andreae, president	
Lesley Patterson, chairperson, aging committee, Metro branch	
Association of District Health Councils of Ontario .....	S-2299
Ken Whiteford, chair	
Susan Brown, vice-chair	
Ontario Federation of Labour .....	S-2301
Julie Davis, secretary-treasurer	
Adrianna Tetley, coordinator, OFL health research project	
Ontario Society of Occupational Therapists .....	S-2304
Christie Brenchley, executive director	
Linda Marshall, member, long-term care task force	
Janet Gleason, chair, long-term care task force	
Canadian Red Cross Society, Ontario division, district of Muskoka branch .....	S-2308
Barbara Gibbs, manager, homemaker program	
Lynn Moore, director, home support services, Ontario division	
Sharon Gillespie .....	S-2311

037481  
Y212  
577



S-71

S-71

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 4 October 1994

# Journal des débats (Hansard)

Mardi 4 octobre 1994

## Standing committee on social development

Long-Term Care Act, 1994

## Comité permanent des affaires sociales

Loi de 1994 sur les soins  
de longue durée



Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

**1944 – 1994**

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 4 October 1994

Mardi 4 octobre 1994

*The committee met at 0908 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Acting Chair (Mr Dalton McGuinty):** Good morning, ladies and gentlemen. Welcome to the standing committee on social development's continuing hearings into the matter of Bill 173, An Act respecting Long-Term Care.

## ONTARIO RECREATION SOCIETY

**The Acting Chair:** Our first presenter this morning will be presenting on behalf of the Ontario Recreation Society. Please step forward and have a seat. Good morning. Would you please introduce yourselves for the record and then begin.

**Mr Malcolm Bromley:** Good morning. I'm Malcolm Bromley, the president of the Ontario Recreation Society. Lynn Briggs is the community facilitator from the Ontario Recreation Society specific to Bill 173, and Wendy Murdock is our executive director. Thank you for giving us this opportunity to address the committee. We've distributed some materials before you which hopefully will help clarify some of the things we're about to state and a video for you to view later.

The Ontario Recreation Society, for those of you who are not aware, is one of the largest and most diverse professional organizations representing recreation in Ontario. Established in 1970, the society's ultimate objective is to enhance leisure and recreation services throughout the province. The society's 600-plus membership is involved in a vast array of services in most district health council geographic areas. Members come from the public service, community agencies, institutions, industry, volunteer organizations, education and the general public. Services are provided to a diverse consumer group, and there is little doubt as to the importance leisure and recreation services play in their lives and communities and in the economy and the environment.

In a review of research studies, Allen in 1991 found that there is conceptual and empirical support for recreation and leisure areas, services and opportunities as contributors to community life satisfaction. He cites one study by Allen and Beattie, 1984, that found a recreation dimension to be the best predictor of overall satisfaction with community life.

Recreation is seen as an effective way for people of different cultures to come together and to develop a sense

of community, with an opportunity to interact with people from other ethnic backgrounds. This was determined in a study by the city of Toronto parks and recreation department, 1989.

Recreation constitutes a major opportunity for people with disabilities to socialize and enjoy social interaction. Leisure is a critical component to quality of life and contributes to health status. This was determined by Burt Perrin Associates, 1989.

Given this relationship, it's often assumed that recreation and leisure are aspects of everyday life that simply happen for people and that those individuals who value recreation will seek it out and be able to access it. For the majority in our society, this is a feasible proposition. However, there are increasing numbers of people in our communities for whom this assumption does not hold. Tangible support systems must be in place for these people. Many individuals who will be affected by the reform of our long-term care system will benefit from an integration of community and health support services and systems. We are concerned for those less able to take advantage of these services.

The recreation profession is already well connected to the community and often plays a coordinating function with many other community and health service providers. The role of the professional recreation provider must be maintained and enhanced within the reform process and framework, not left to chance for discretionary consideration.

The basic principles and goals of long-term care reform and Bill 173 complement and echo the foundation upon which recreation services are designed. We believe in both local and individual focus with maximum consumer input.

The Ontario Recreation Society generally supports and endorses the goals and principles of long-term care reform and Bill 173. However, more must be done to entrench recreation as a critical element. We are certain that the profession is responding to the critical issues that our citizens and communities face in the 1990s and believe that decision-makers must fully integrate and recognize the role of the qualified recreation professional. This includes Bill 173 specifically and those responsible for its development.

**Ms Lynn Briggs:** To reiterate, the Ontario Recreation Society is pleased that Bill 173 has identified social or recreational services as a community support service that multiservice agencies must provide or ensure the provision of. All consumers of long-term care services will

have leisure needs, and at least on the surface Bill 173 appears to have acknowledged this fact.

From a consumer perspective, evidence suggests that recreation is considered a vital part of rehabilitation, prevention and ongoing wellness. Leisure and recreation are among the core support services which currently assist people to remain involved and connected as active members of their communities. However, Bill 173 has not identified social or recreational services. As a result, there is potential danger in district health councils interpreting and delivering the service in an ineffective and inconsistent manner via the multiservice agency.

In addition, consumers, recreation professionals and other service providers are more familiar with the service being identified as leisure and recreation services. Social contact and socialization are benefits of leisure and recreation participation as opposed to a direct service area. All leisure and recreation services have in fact a social component. Therefore, we recommend that references to "social or recreational services" be renamed to "leisure and recreation services" in Bill 173. It is further recommended that the service be specifically defined under part II, subsection 2(1), with input from the profession through the Ontario Recreation Society.

Investment in recreation as a preventive health service makes perfect sense. With reference to the purposes of Bill 173, we believe that continued investment in this service area will positively impact on the health and wellness of consumers of long-term care.

The government has made a commitment to incorporate wellness into its design work for all programs and services in the long-term care system. It is our belief, however, that the system design in general continues to adhere to the medical model of service delivery, where expensive and intensive treatment appears to be a priority over the more cost-effective benefits of wellness-oriented service provision. While it is prudent to build upon the good parts of our current system, it takes a true redirection to integrate health and social services in a way where health promotion and wellness become the primary focus of all service provision.

As recreation professionals, we are very familiar with the long-term social and physical benefits derived from adopting the principles of independent, healthy and active living. In other words, we believe that we "walk the wellness talk" on a daily basis by the very nature of the services we provide.

Active living generally, through the opportunity of leisure, is one of the very best methods of health insurance for individuals. There is an extensive body of research, some of which we have provided for you, indicating the ways in which recreation and leisure interact with a person's health and general sense of wellbeing.

To varying degrees, all services that are to be provided by a multiservice agency have health promotion and wellness components, but often it is not a primary focus of their service provision. Leisure and recreation services consider health promotion and wellness to be a primary benefit of participation and, as such, have a vital role to play in any plan of service for individuals utilizing the long-term care system. We are aware that a provincial

policy framework on wellness related to long-term care client groups is currently under development, but we have to wonder why more reference is not made to health promotion and wellness in Bill 173 legislation.

Even though the benefits of leisure and recreation services appear to be crystal-clear, in our work at the district health council level we have been witness to the near or absolute exclusion of social or recreational services as a necessary partner in the circle of service to be included in the multiservice agency design.

The Ministry of Culture, Tourism and Recreation has produced a video—you also have a copy of that in front of you—titled *Growing Stronger: The Benefits of Sport and Recreation*. The video reiterates the benefits of investment in recreation by stating: "Public sector funding of recreation programs illustrates the old adage: Pay now or pay more later.... An investment made today achieves and maintains increased physical and mental health among the population, lessening future health care costs." This would suggest that it would be prudent to ensure that sufficient financial resources are maintained to provide for leisure and recreation services for consumers and care givers.

The Ontario Recreation Society is able to provide details of recreation service provision options which are fiscally responsive, which have proven effective in rehabilitation and health promotion and which have incorporated collaborative planning with consumers, their families and other service personnel. However, due to the vast array of service options in terms of leisure and recreation, the Ontario Recreation Society believes that the purchase-of-service limitations for multiservice agencies will severely restrict the consumer's right and accessibility to choice of service options. Therefore, we recommend that social or recreational services be exempt from any purchase-of-service limitations.

The leisure needs of consumers must not be overlooked. Leisure provides the opportunity to lead balanced lives, achieve our full potential and gain life satisfaction. The opportunity of leisure is essential.

**Mr Bromley:** In conclusion, the Ontario Recreation Society reaffirms our commitment to working as a collaborative partner in the reshaping of the long-term care system in this province. We believe our service is essential to the consumers of long-term care and we are working diligently in our communities to ensure the provision of the service within multiservice agency frameworks for them. The inclusion of leisure and recreation services cannot be left to chance, and we are confident that the recommendations contained in this brief will assist in positioning this service as an integral and essential part of the service framework in communities across the province.

In short, the benefits of leisure and recreation services cannot be ignored. Investment in recreation makes sense.

**Ms Jenny Carter (Peterborough):** Thank you and welcome to the committee. I don't think there's any dispute that wellness has to be the prime focus and that we want to keep people well rather than see them get sick when that could have been prevented. It seems to me that some of that is programmed into what we're doing.

I'll just outline what I see as being there, and perhaps you could tell me what you feel needs to be added to the mix, as it were.

Certainly in Bill 101, which covered the institutional side of long-term care, I know that programming of various kinds is funded. I believe it's left to the individual place to decide what they will spend that money on, but I believe that component is in there.

0920

For people who remain in the community, I think what we're looking at is—I don't know whether you'd call it a day centre or what, but somewhere where a person can go and spend one or several days a week. It seems to me that there would be recreation within that, as part of what they would do during that day. Certainly I know that in my own riding of Peterborough we have Activity Haven Seniors' Centres and we have places where people can go and do carpet bowling or sing or whatever. Also, I've visited places which are centres for seniors where they have things like line dancing and t'ai chi and so on. So those things are there in the mix. I'm just wondering what you feel needs to be done, what you feel is inadequate about the situation.

**Ms Briggs:** We certainly agree that there are services available in the community at present. That's not really what our issue is. Our issue is that there is a population or clientele of long-term care consumers that we believe will not be assisted to access those services through the MSA design. We have found that already in our work, as I stated, at the community level, that there are not any mechanisms at present being put in place to ensure this group of folks receives leisure in their lives, which we believe to be very important.

**Mr Bromley:** If I could just add a comment to that, the way we like to see it is that there are some bridges that need to be built between some of the existing services and some of the clientele who are receiving services through other methods now, through institutions and other traditional models of health care provision. The linkages are not quite there in some communities. We have, on a positive note and a constructive note, tried to help district health councils link up with local recreation providers to make sure those linkages are there.

So the active and the well can quite readily access traditional recreational and leisure services, as you outlined. It's those people who, for whatever reason, whether it's disability or age, have a number of barriers in front of them. We think that it is right now a leap of faith that the clients who are using long-term care facilities would be able to benefit from those services as presently developed.

**Ms Carter:** But of course there is a category of people who are not at the point where they need to access health services, who are being kept well because of things that are there anyhow.

**Mr Bromley:** Because of us.

**Ms Carter:** I mentioned Activity Haven. That would cater to a lot of people who wouldn't be calling that phone number to ask what services they could access because they're beginning to feel sick or whatever. So I

guess if we're really looking at wellness, we're looking at people in that stage and hoping to keep them there so that they really wouldn't come under the orbit of the MSAs, but nevertheless the services should be there.

**Mr Bromley:** It's a range of service that needs to be in place, from those who are very active to those who are very inactive. But we all need leisure, we all need healthy recreation, and I think we can look at personal examples of ourselves and family members who, without that active leisure component, can slowly deteriorate and then become—it's not only a human tragedy for the individual and the family; it's a fiscal tragedy for the province.

**Ms Carter:** Absolutely.

**Mr Bromley:** I understand that that's what we're all concerned about.

**Ms Carter:** As I say, we're looking at a continuum of services that starts outside the MSA framework, and then ultimately people would be included within that. I guess the services of that kind that are there already would come under an MSA. I wonder if we could maybe have some clarification on that, as to what the scope is likely to be, whether the things that cater specifically to wellness are going to be included under that umbrella.

**The Acting Chair:** Parliamentary assistant?

**Mr Paul Wessinger (Simcoe Centre):** I probably will ask the policy person to elaborate more, but it would appear to me that if we look at the people who would be served in the long-term care system in the community, it will be those people who are recovering from an acute care situation, which is about 50% of the people involved, I believe, and the other people are those we would call the frail elderly. Certainly I think it's the latter category, perhaps, the frail elderly, where you'd be looking at the social and recreational services. I think it's very clear that there is a need for some type of services to those people to enrich their lives.

I would assume that probably the best way of providing that would be through elderly persons' centres, but I will ask Mr Quirt. Perhaps he could add his more extensive knowledge in this area.

**Mr Geoff Quirt:** Certainly the elderly persons' centres are involved in an important way in providing social, recreational and leisure activities for elderly people. Normally, our contribution is in addition to the contributions made at the municipal government level, and often it's the municipal recreation department that has the primary focus on providing those services.

We make a modest contribution to elderly persons' centres, up to \$30,000 a year. Clearly, elderly persons' centres, as our policy documents have indicated, should be considered in the planning for the new long-term care system and MSAs, but there's no problem with them remaining separate and being funded separately. For the very reason that the presenters have mentioned, the fact that often people with disabilities or frail elderly people have difficulty accessing leisure or recreation services, we made social recreational services a mandatory service for multiservice agencies to deliver. So each multiservice agency will have to pay attention, by law, to the social and recreational needs of its client group.

**Ms Briggs:** We were just concerned that the interpretation of multiservice agencies may be somewhat different than contained in the bill, and that's been our actual experience. So we wanted to come here today and reiterate the importance of the service.

**Ms Carter:** Certainly we see wellness as being very much part of it, and of course for seniors who are more active we do have the Ontario Seniors' Games program, which I saw quite a bit of this year. You have competitions in each local area and then they went to Sudbury for the finals. That was really quite a large project. It was funded, I believe, by the province. So that's looking at the point people are at before they would come under an MSA-type arrangement. I hope and believe that that's included.

**The Acting Chair:** Thank you very much for your presentation.

#### CATHOLIC WOMEN'S LEAGUE OF CANADA

**The Acting Chair:** Our next presenters are here on behalf of the Catholic Women's League. Good morning. Welcome to the committee.

**Mrs Patricia Beattie:** My name is Patricia Beattie, and I'm a member of the Ontario provincial executive of the Catholic Women's League of Canada as well as president of the Toronto archdiocesan council of the CWL. With me today is Moira Ste Marie, another member of the provincial council, and Dorothy McGuigan, president elect of the Toronto council.

The Catholic Women's League has been active in communities across Ontario for over 74 years. We currently have over 65,000 members across the province, almost 8,500 of whom are based in Toronto.

Our members are active volunteers in their communities. They donate their time and raise money to support local organizations. In the Toronto archdiocese alone, we estimate that over 100,000 hours per year are spent by our members working with organizations such as the Arthritis Society, the cancer clinic, Meals on Wheels and Providence Centre and providing services such as non-medical palliative care, home visits and transportation. In the entire province, it is estimated that over 400,000 hours of volunteer time are spent on various tasks.

Over the years, the CWL has been active on various pieces of legislation at all levels of government. We increase our efforts when we have major concerns regarding the policies being proposed. We have serious enough concerns with some of the proposals contained in Bill 173 that we felt it important to state them publicly to you here today.

0930

From our perspective, the piece of legislation which you are studying will do serious harm to the volunteer element of many organizations within our communities. Volunteers will be demotivated in terms of giving their time, sharing their expertise and raising funds for many needy organizations.

Working with volunteers every day, we are well aware of what is required to both attract them and keep them involved. Commitment must be built, they must feel that their contribution is valued, and they must believe that if

they are not doing the job, the job would not be done and someone would be suffering.

Under the current provisions of Bill 173 and the resulting absorption of many community agencies into a government-mandated MSA, we do not believe these elements will exist. By leaving only the names and logos of organizations and taking away their independence, you will remove the individuality of the affected groups, their innovation, their spirit and the rationale for many to participate in their activities.

We have spoken with many of our members about this issue, and we always receive the same general response: "If the government is providing the service, our help is not required. The need is not the same. We will devote our energies to activities which need our help more."

As Minister Grier stated when she appeared before this committee, "As a volunteer...I decide what kind of agency is most compatible with the kinds of objectives I want to achieve and satisfactions I want to achieve as a volunteer, and if that agency doesn't provide me with that sense of satisfaction, well then, there are lots of other roles in which I can fulfil my volunteer responsibilities."

We agree. CWL members and councils work with a wide variety of organizations, some of which will be affected by this legislation and others which will not. It is not difficult for our members to refocus their activities and concentrate on projects such as working with homes for unwed mothers rather than delivering food as part of a local Meals on Wheels program, or increasing the time spent in home visits rather than assisting the Arthritis Society. Our members will not be the ones who suffer; rather, it will be those organizations and the people they serve, all of whom depend on the time given by volunteers to properly deliver their services.

Has the government taken these possible losses into consideration? Have you done the financial estimates of what it would cost to replace the lost volunteers with paid workers just to be able to continue the same level of services?

We have done some estimates of our own. Based on volunteer hours, estimated at 400,000 a year in Ontario, and using a sum of \$15 per hour, the total amount of volunteer time spent by CWL members last year would cost \$6 million to replace. Now, given that we do not devote all of our time to organizations which would be affected by Bill 173, we reduced that amount, cut it in half in fact. Even at that, the total remains over \$3 million. In our view, that is a significant amount of lost resources which will have to be made up somewhere or services individuals need, and received in the past, will disappear. These figures are just for our organization, not taking any other volunteers into consideration. The CWL believes these are facts which must be given serious consideration by this government before it proceeds any further with the legislation.

Additionally, a significant amount of money is raised by CWL members which would likely be lost by the passage of this legislation, as well as the loss of volunteer time and commitment. Again, taking 50% of the total, we estimate that over \$800,000 of forgone fund-raising moneys will be the result of Bill 173. If this money is not

replaced from somewhere, services will be ended or cut as a result. Where will these extra dollars come from?

I would like to urge the government to take the views it has heard through these hearings, not just from us but from many other organizations which have grave concerns about this bill, and reconsider its future. From our perspective, the loss of volunteers and the associated cost of replacing them are too great to be thrown away in the current manner. The necessary parts of the bill—easier access to information and the bill of rights—can be achieved without the destructive sections which currently exist.

On behalf of the 65,000 members of the Ontario Catholic Women's League, we thank you for the opportunity to appear before you today.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Thank you very much for coming. Your brief is very explicit and self-explanatory. I think, if I may, I would like to go just a little bit below the surface of your brief. I understand that this morning at 11 o'clock you're going to be part of the coalition—at least your name is on as one of the members of the coalition—that has approached the Premier about the seriousness of what this bill entails.

I'd like to ask you, and I'm sure it won't be easy for you to give me the exact reasons, why you joined the coalition; what you see beyond what you have in your brief, which are two very poignant and fundamental reasons why this bill is certainly putting many organizations in jeopardy and certainly the efforts of many individuals whom you represent in question. I'd like to know what it's doing to those organizations that you so well describe that your members are part of, whether they be Meals on Wheels or whether they be the cancer society.

Could you say a little bit about what the effects are? There have been real criticisms that we're only hearing from the providers, that we're not really hearing from grass roots, and I think you're the grass roots.

**Mrs Beattie:** One of our very grave concerns is the loss of freedom of choice, not only for the consumer but, from our particular perspective, from the point of view of the volunteer. We would lose freedom of choice of what organizations and institutions we would support with our volunteer time and with our volunteer dollars.

**Mrs Moira Ste Marie:** If I may add to that, I really feel we are the grass roots, because we are assisting people in their homes. We are doing it at all stages of life, from the very young right through to the very old. Our women are people who have jobs, they are people who are at home, and they see the needs in their communities. So they relay those needs to members of this group, and people react because we are there for a common goal.

**Mrs Dorothy McGuigan:** May I add to that? The religious and cultural choices will not necessarily be there, because we are a religious-affiliated organization. For some of our elderly, religion and culture are very vital to their health and welfare. Through the existing non-profit organizations, a lot of the services are offered in three dozen languages. That may not necessarily be

something that the large, monopolistic MSAs are going to have the ability to attain or to even afford. So this is something that concerns us, because we are a caring organization and we are really interested in the religious and cultural aspects of this bill.

**Mrs O'Neill:** I think you have represented the grass roots. I think the grass roots understand what this bill is about, and the fears and doubts are very well placed, I think. I'm just going to ask God to bless your every effort. Thank you very much for coming.

**The Acting Chair:** Thank you very much for your presentation.

0940

#### CITY OF TORONTO LONG-TERM CARE NEGOTIATING COMMITTEE

**The Acting Chair:** Our next presenters are appearing on behalf of the city of Toronto long-term care negotiating committee. Welcome to the committee.

**Dr Perry Kendall:** Thank you for this opportunity to respond to Bill 173. I am here today not as a medical officer of health for the city but as chair of the city's long-term care negotiating committee, which was set up almost three years ago as part of a larger city-wide process for examining and responding to the government's redirection of long-term care. My copresenters, Ms Bea Lewis is chair of the Toronto Mayor's Committee on Aging, and Councillor Elizabeth Amer also represents that committee. They will both be speaking today.

We in the city undertook in 1991 a six-month process of consultation where we talked with a host of stakeholders: seniors' networks, disabled persons' organizations, ethnocultural groups, service providers, informal care givers, residents of facilities, city departments, representatives of native Canadian seniors and the Social Planning Council of Metropolitan Toronto. What that taught us was that there are no new issues in long-term care reform. The old issues—one-stop access, a full range of services in the right place at the right time, maximum allocation of precious resources to service delivery—have been discussed long enough and well enough to warrant the current legislation. So I'd like to begin by expressing our great relief that Ontario is at the point, I believe, of putting in place a reformed system of long-term care.

The city's position regarding Bill 173 is outlined fully in the report from Toronto city council which has been tabled with this deputation. While the city supports the intent and much of the substance of Bill 173, the report does express some important concerns.

I'd first, however, like to note with approval the flexible framework for service delivery provided by the bill, a framework in which small service agencies can maintain their identity within a multiservice context. Building an improved system with these agencies will ensure an ongoing role for the groups and individuals who know their communities best and understand the needs of the people who live here. It will also, I believe, address the criticism that I just heard this morning that volunteers will lose their altruism and desert the new system. The visible continuation of agency identity will help assure their loyalty and responsiveness to community needs. I don't believe that the well of altruism in the

Ontario community will dry up as a result of the proposed changes in this bill.

However, considering the legislation's flexibility and the purpose put forward in clause 1(g), to encourage local community involvement, subsection 11(3) of the act is perplexing. This is the section that states that before designating a municipality or a board of health as an MSA for a geographic area, the minister shall consider the suitability of all other approved agencies.

Public health units presently administer 29, I believe, of the province's home care programs. They've done a good job and in some areas might well emerge as a natural community choice for an MSA. I believe that section 11(3) limits a community's ability and right to plan, and the city of Toronto strongly recommends that subsection 11(3) be struck from the act.

We note too that health promotion and wellness are not addressed in the legislation, which is a cause for concern. The government's implementation framework from 1993 made a commitment to incorporate wellness into all programs and services in the long-term care system, and the city recommends that health promotion be included as a key service under the current legislation and that multiservice agencies be required under the regs to develop and implement comprehensive wellness plans for the communities they serve.

**Ms Beatrice Levis:** Community-based reform of the long-term care service system has been on the seniors' agenda for many years. When some of us started out on that agenda, it was not a personal priority; now it has become that, too. Not that most seniors are not healthy, but the probabilities are now weighted a little more against us.

I want to say straight off that as welcome as this reform may be it will never work without sufficient funding. If seniors are to stay in their homes—and that's where most of us want to stay—we're going to need funding for all the community, personal and professional support services to make it possible. No less important are funds for family support groups, respite care and the expenses of informal care givers.

We need to see the government's plan for resourcing long-term care, and we want it to include adequate global funding for each MSA. As other parts of the health care system are reformed—for example, as hospital stays are reduced—we also want to be assured that those dollars will follow each person discharged into community care.

I just want to digress a minute. We have files that indicate that many elderly people discharged early from hospital have been at risk and that this has resulted either in death or in longer hospital acute care in the end. So we're very, very concerned about convalescent care being built into the long-term care system.

In this regard, we are particularly concerned that the regulations of the act could open the door to charging user fees. When regulations are being drafted, we urge the government to let consumers like us have our say. We have always said, and we intend to continue to say, loud and clear, no to user fees. We also want input to the regulations in order to protect other rights and interests,

including the right to be on the boards of multiservice agencies in more than token proportions.

We endorse local accountability and recommend that the regulations require public records and open meetings of multiservice agencies as well as public input.

We want the government to set up a process for monitoring the four-year phase-in of MSAs to be sure that the new structures and services are flexible enough to serve the needs of consumers and the intent of the act.

We ask as well for some flexibility in the 20% ceiling on purchases of service by an individual MSA so that all needed services can be covered.

The appeal process in Bill 173 is confusing and appears to overlap with the workings of the Advocacy Commission. We ask the government to clarify the role of the Long-Term Care Act in relation to the Advocacy Act so that there is no confusion or duplication of function. Duplication is a luxury the long-term care service system simply can't afford.

In ending my remarks, I would like to express our support of the bill of rights, which strongly confirms consumer choice and dignity. We believe, however, that the bill of rights should begin with a clear statement of the fundamental right of all citizens of Ontario to access the long-term care service system and we ask that it be amended to include this statement.

**Ms Elizabeth Amer:** If I may refer members of the standing committee to the report of city council mentioned earlier by Dr Kendall, the report was passed recently by council and, as such, it is our official response to the current legislation. My remarks will colour in some of the content and recommendations of the report, but much more is contained in that document, more detail than I can cover here today.

I'd like to reinforce comments made by Bea Levis, in particular the need for adequate resources to carry out the reform. I think it's fair to say that much of the criticism of the proposed reform, criticism that's been heard before this committee, has grown out of the fear of giving up an imperfect system for an unknown system.

If consumers and service providers alike could be assured of sufficient global funding for each MSA to maintain current local resources and meet new needs, much of that fear and criticism, I believe, would disappear. But until those agencies and individuals get that assurance, it's reasonable to expect smaller agencies in particular to displace their fears about survival on to the multiservice concept itself.

Hence, I believe it's the responsibility of the government to clearly articulate a plan for funding long-term care that can sustain the system through the implementation phase and for many years to come.

0950

A separate but related concern has to do with informal care givers, those extraordinary people, overworked, underrecognized—women largely, in my experience—who save us countless public dollars through selfless care giving. They don't need to have more responsibilities placed on them as a result of insufficient service funding. They do need our help; they need resources for respite

care; they need support groups and essential materials and supplies. In this regard, I would request that the government listen to and act on the recommendations of the interministerial task force that is currently investigating compensation for informal care giving.

May I also draw your attention to recommendation 4 in the report of Toronto city council, that dental services for seniors be included in the professional services mandated under section 2(7) of the act. I should tell you that I say this with some passion, having a toothache as I talk to you this morning; entering my 56th year with a toothache, it certainly means a lot to me, that part of it.

As a city councillor, I'm very aware of how the present system fails the needs of shut-ins and recluses. I represent an area in downtown Toronto where isolation of seniors is really a serious problem, especially those who don't speak English or who speak very little English. I strongly support recommendation 5, to include funding for crisis intervention advocacy and follow-up programs.

Finally, I'd like to say how important we believe it is for multiservice agencies to function autonomously. Let me underscore recommendation 11 and say that we do not want section 52(2) of the act to be interpreted in regulation in any way that would undermine local autonomy and accountability.

**Mr Jim Wilson (Simcoe West):** Thank you, ladies and gentleman, for your presentation on behalf of public health in the city of Toronto. Councillor, I note that recommendation 4 in the city of Toronto report does ask that we include dental services under this act, professional services. When you're of age, I suppose, that might become of some help.

I should say, though, that I don't share the report's, and Dr Kendall's, comments. In particular, I don't share the optimism with respect to the flexibility that you see in this act. I'd ask you to take this opportunity to qualify a couple of statements on page 3 of the city of Toronto public health department report.

One of them, in the second-last paragraph, is, "The act would appear to provide a flexible framework for service delivery that makes it possible for a variety of service agencies approved under the act to maintain their identity and integrity within an improved system." I should just say I don't see that, and it seems to run contrary to well over 90% of the presentations we've had to date.

Perhaps you, as a member of the negotiating team, know something more than we do, but when 80% of the services after a four-year period have to be delivered by one agency called the MSA and when the VON and Red Cross and Saint Elizabeth visiting nurses and major organizations in this city and province tell us that they're out of business, when we've had discussions about the government buying the VON cars and paying severance for the nurses to become employees of the MSA, I don't see how they retain their identities. I'd like you to just comment on the flexibility that you see there.

**Dr Kendall:** When I looked at the framework of the act and when I looked at the work that preceded the act, it was clearly the intent that existing agencies could become part of, and maintain their identity of a logo,

within a multiservice agency, and that was specifically designed to maintain their expertise and interest. I understand that for some agencies like the Red Cross their charter in fact would prohibit them from becoming part of a multiservice agency, but my answer to that would be that one could change one's charter if one wanted to continue to be in that business. But as they exist, and as one of their executive directors told us some two or three years ago, they are in the business of serving the public, and if another agency could serve the public and they couldn't change their charter, then the public got served.

Parenthetically, I think, the issue here is, from the data I've looked at, that Ontario spends more on long-term care and home care than any other province on a per capita basis or on an age-adjusted basis. Yet we have a system of services which is a lot less easy to access, a lot less continuous, a lot less accessible than many other provinces that spend 30% less than we do on a per capita basis. This is because we've chosen to build our system over 30 to 40 years on a number of distinct agencies and some larger agencies, and purchase of service.

If we are to direct that scarce funding to meet the needs of the populations we want to serve, we're going to have to do something about the current delivery of service. That I think, in some cases, will mean unbundling parts of services for direct delivery and will mean agencies coming together to work underneath a governance structure to eliminate duplication in administration, duplicate assessments etc. In some cases, I think that will happen to some agencies.

**Mr Jim Wilson:** We do have agreement, I think, among all parties that yes, the system needs to be better coordinated and people do need to come together, but first of all, I don't think the bill even preserves the logos of these local community agencies currently in existence, and preserving the logos wouldn't go far enough. When you're dealing with the Catholic Health Association of Ontario and many of the different religious and cultural agencies that we have out there, the logo is not what's important, it's the mission statement. All of those mission statements are to be absorbed into the multiservice agency, which we see as an arm's-length government agency that indeed will be monopolistic in terms of delivery of services.

The second thing is that you talk about multiservice agencies essentially in the next paragraph, "The act also appears to negate any perception that multiservice agencies will be overly bureaucratic, will reduce consumer choice or deliver service of inferior quality."

We are very much concerned about the bureaucratic nature of these. It has not been proven in the history of this province that bigger is better. In fact, the trend in business and the trend in many other governments now in North America, as you know, is to move towards smaller units of system delivery. We may be, with this bill, replacing several little agencies which, upon examination, actually are fairly efficient given that many of them just have an executive director and maybe a couple of staff and then hundreds of volunteers. We may be replacing that with a large bureaucratic multiservice agency with

several departments that people will be shifted around to.

Certainly, our experience with regional government and other types of comings together of government bureaucratic institutions has, in my opinion, not proven to be the most efficient way to deliver services, and the public seems to want government to go in the opposite direction. Do you want to just comment on that sentence you have where you don't see any of that in this bill?

**Dr Kendall:** I think it would be perfectly possible to design a system that did have layers and layers of bureaucracy inherent in it. I'm actually confident in the abilities of the district health councils and the consumers and the service providers that sit on them to redesign a system that doesn't incorporate layers of bureaucracy and that is responsive, with local access points, and at the same time diminishes the amount of administration and overhead that currently exists in the large numbers of service deliverers and the brokerage system we currently have.

I base this on some knowledge of the local district health council planning process. I also base it on some experience from British Columbia, where they do have a much more integrated service delivery system. It works well and flexibly and responsively.

**Mr Jim Wilson:** I appreciate it. Mr Chairman, Mr Jackson would like a short question.

**Mr Cameron Jackson (Burlington South):** Ms Levis, I appreciated receiving your contribution to this brief. I'm concerned, and can only concur, that your fears are legitimate when you say that as long as there's the appropriate funding we can meet the assessed needs of seniors. You go on to suggest that there be no user fees, yet when I look at recommendation number 14 from this city of Toronto public health department brief that's been passed by city council, number 14 says, "That the government amend section 12(2) to allow MSA boards to provide optional services without the consent of the minister, so long as these services are not paid for out of public funds." I read that to indicate that they want further authority to charge user fees without consulting the minister. Is that how you read that, and could I get some feedback from you as someone whose interest in this is on behalf of consumers of these services?

**Ms Levis:** Yes. I think there is a difference between the type of services that one must receive in order to remain healthy and independent—for instance, visiting by a nurse and that type of thing, or dental care, which is absolutely necessary—and the kind of service which has to do with maybe getting the roof repaired or some other optional type of service which is required in order to maintain the home. I think the difference here is that 14 is not contradictory in the sense that what is being directed there are the kinds of services over and above those that are deemed necessary for maintenance of health and wellbeing.

1000

**Mr Jackson:** Very briefly, Ms Levis, you realize that there are user fees built into the language of this bill and that there are user fees right put through the system currently. One of the concerns that has been expressed is that when we as a legislative body amended Bill 101,

institutional care and long-term care reform, it resulted in \$150 million to \$160 million of increased user fees for residents. There are legitimate concerns when issues around user fees are raised.

Let me just put a fine point on this, and that has to do with the question my colleague, Mr Wilson, raised about how there's more to the logo of, say, the VON or Saint Elizabeth visiting nurses, when you consider that many of these agencies currently, and I always think of the Catholic agencies when this comes to mind, will take a person who, based on their needs, cannot afford the user fees that are riddled through our long-term care system currently and will occasionally say, "We'll pay those costs, we'll absorb those costs." I consider that as valuable as the potential loss of volunteers.

This isn't a debatable point. It's clear that we will lose those agencies being able to take those costs and absorb them on behalf of persons less capable of paying, and that would be a serious loss to this system. Have you given any consideration to, or done any examination of, those agencies that are currently insulating seniors from these additional costs that keep surfacing with great regularity in these reforms?

**Ms Levis:** The mayor's committee on aging itself has not done any investigation. We take the stand that studies have shown that user fees in general by government-operated programs are counterproductive and penalize those who need them the most. By the way, we did object to the increase in fees in institutions. It's part of our general approach that user fees are counterproductive, penalize those who can least afford it and result in more bureaucracy, not less.

**Mr Jackson:** Thank you very much, Ms Levis. We are entrenching in this legislation the fact that MSAs will not have the flexibility to say, "We're not going to charge fees to this group of citizens but charge fees there." That flexibility has been removed from this legislation. That is one of the things we were looking for. Again, my colleague Mr Wilson was trying to stress what was meant by flexibility, but on user fees we see this bill as having less flexibility to deal with those. We would commend you to monitoring that with us because we're very, very concerned about it for seniors in the province.

**The Acting Chair:** I wish we could continue, but time simply does not permit.

**Dr Kendall:** Could I make one very brief clarification? This is a report from the long-term care negotiating committee and not just from the department of public health, and that includes representatives from the board of health, the Toronto Mayor's Committee on Aging, the mayors committee and the neighbourhoods committee.

**The Acting Chair:** Thank you, Dr Kendall.

EVELYN FISHER

**The Acting Chair:** Our next presenter is Evelyn Fisher. Good morning, and welcome to the committee.

**Ms Evelyn Fisher:** I'm pleased to appear before you as a consumer of community health services. I would like to give you a few examples describing my involvement as a consumer and a volunteer in the community health service system.

Last summer, during a very serious illness, I was fortunate to be able to remain in my home with Saint Elizabeth visiting nurses monitoring my intravenous medication therapy. During that two-week period, the Saint Elizabeth nurses monitored my progress and response to treatment. The nurses visited me once every eight hours to administer my antibiotic therapy via a saline lock. The home care coordinator met me in the emergency department at Oshawa General Hospital and arranged to have Saint Elizabeth nurses provide my care because of their recognized expertise in infusion therapy in the area.

During the past four years, I have been a volunteer board member of Durham Region Community Care Association. My responsibilities included being the chair of the human resources committee. This not-for-profit organization provides community-based support services for the elderly and adults with physical disabilities. Durham Region Community Care was very proactive in the long-term care new direction discussions in the region.

My experience with VON occurred in the spring of 1992 during my placement as a management intern. This experience increased my knowledge and understanding of the role of the home care programs in arranging for home care services in the Durham region. At this time, I also became aware of the critical role that volunteers have in enhancing home and community programs and services.

My interest in long-term care further developed as a professor in the faculty of community and health services at Sheridan College. My involvement with all these organizations has kept me well informed of the Ontario government's goal to redirect long-term care and health services in a more comprehensive, accessible and fiscally responsible manner. Currently I am the consumer representative and chair of Saint Elizabeth Visiting Nurses Association Durham advisory committee. Today I will address my concerns with this proposed legislation as a consumer and as a stakeholder.

My concerns, first of all: The proposed MSA structure will be providing consumers like myself with a menu of services. However, we will not know what the ingredients are or the quality of the final product. We now have reasonable knowledge of the quality and end product of the programs and services provided by the existing not-for-profit community health services providers.

Because organizations such as Saint Elizabeth visiting nurses have a philosophy and a value system in place, their committed staff have provided consumers like myself with compassionate, holistic care. My case manager and her coworkers incorporated the critical biological, psychosocial, spiritual and environmental aspects into my plan. These nurses recognized the importance of addressing my self-esteem and sense of self during this crisis. The nurses became advocates on my behalf when the home care coordinator suggested that I do my own IV medication administration. These nurses were able to provide the home care supervisor with factual information of why this was not possible.

How will an agency which is both funder and provider be able to be an advocate for clients?

A major area of concern is the elimination of the current charitable provider organizations. In the proposed legislation, these current providers will be eliminated, with perhaps only 20% of services which will be contracted to selected provider organizations. The ultimate goal is to have the MSA provide 100% of services.

This proposed one-stop shopping is actually a monopoly. In the former Soviet Union, there were government-run department stores. However, the consumers were not provided with much selection. Healthy competition promotes innovation, flexibility and fiscal responsibility. My fear is that this competitive innovative spirit will be lost with the proposed MSA structure. The losers will be us, the consumers.

#### 1010

Another area of concern is the length of time from referral to an MSA, the assessment, determination of eligibility and provision of service. Who will be doing this assessment, a generic worker or an experienced professional, such as a nurse?

Maintaining the high quality of service as currently provided by existing agencies is a big concern. The staff in the current provider organizations have a history, an identity of who they are and they have developed positive relationships with their communities. This sense of identity stimulates strong commitment to an organization and the quality of services provided. These existing agencies also provide their staff with training and up-to-date education. How will the proposed MSA structure ensure that the staff are kept up to date with current knowledge, techniques and skills required in an ever-changing health and community service environment?

What will replace the current volunteers who so closely identify with those chosen organizations? I volunteered for Durham Region Community Care and Saint Elizabeth visiting nurses because their philosophy, values and goals fit with mine. Individuals volunteer for organizations for reasons similar to mine. It would be very difficult to volunteer for a government-mandated agency that had no history or identity and that is primarily a government agency.

In summary, the proposed legislation seems intent on burying the current charitable community health service provider organizations and the quality of services provided to us, the consumer. I am concerned, as a consumer, that the new proposed structure will limit my ability to make informed choices regarding services and the service provider.

The proposed legislation will create financial burdens on consumers for purchasing services if we do not meet the eligibility criteria.

A comprehensive review of long-term care certainly was needed, and the government did have stakeholders participate in the discussions. Consumers and other agencies did not anticipate that this would result in the dismantling of the existing provider agencies.

My recommendation is, fine-tune the wheel, don't reinvent it.

**Mr Larry O'Connor (Durham-York):** I appreciate you coming as a consumer of the services in Durham

region. I'm a resident of Durham region. I live up in the north part of Durham region. We've got a small part of Durham Region Community Care that's reflected in Brock Good Neighbours. I wouldn't say my constituents in the north, through that agency, are given all the services that are more available in maybe some of the more populated parts of Durham region.

In fact, sometimes when you get an agency such as Durham Region Community Care that does all of it that's, as you say, near perfect—you know; not quite—we end up seeing bureaucratic decisions made like sending somebody all the way up to Cannington to clean the typewriter because somebody down in Whitby suggested it was time to get that done. That's not really, I think, good, efficient use of dollars for all the money that was spent for somebody to go up there and do that. We've got a coordinator up there who pulls together some of the services that are necessary, and I think that's an important role that needs to be played.

I think when we take a look at the continuum of care that is needed, we don't have a wheel that needs to be fine-tuned in every community. I think in some cases maybe it can be fine-tuned, and when you pull the community together and you involve everybody, we're going to end up with something that's going to be better than we have in place today. In some areas, it's going to require more work than others.

Consumer involvement is going to be a key to this change, because the important thing here is what is needed by the consumer, and it isn't necessarily going to happen by maintaining the multiplicity of agencies out there, and all the different administration costs that are reflected in that. What is necessary here is something that is going to grow from the community up, and I want to make sure that in my part of Durham region, whether you live in Gamebridge or whether you live in Uxbridge, you're going to have an opportunity to be involved in that. There are services provided there today, and I don't want to see any of my constituents that are needing those services as a consumer be denied.

In fact, I know there's been a lot of money that has gone into the community side of health care. It's something that is often overlooked by people when they reflect on the accomplishments of this government that there's been a 54% increase in the funding on the community side of long-term care. This year the total is going to reach \$850 million, which is over \$300 million more than what was there in 1990. The dollar commitment is there, and what we want to do is involve as much of the community as possible, from the volunteers right up, and we want everyone to be involved in that process.

I appreciate that you've been involved in it and I hope you continue to be involved in it. Maybe you can explain some of the role that you've played in working with the long-term care committee with the district health council to make sure that your role as a consumer reflects some of the needs of the consumers from the part of Durham region you come from.

**Ms Fisher:** My role was as a volunteer with Durham Region Community Care and currently with Saint Elizabeth. I was not involved with the district health council.

There were people from these organizations that were involved.

I'd really like to take point on your talking about Brock region not getting the services that they want and the best way of dealing with this is by dismantling the current organizations so a new structure could be created. I really don't understand how that's going to be a cost-efficient way for the consumers in Brock to get services. Certainly they need services, but to say that we would dismantle what is already provided by the existing agencies I do not feel will address the problems of consumers in Brock or in Oshawa, where I live.

**Mr O'Connor:** The important thing here is not to try to dismantle everything that exists today but bring what exists today and pull together and involve the consumers so we can evolve so we make sure that the people up in the north part of Brock township have the same availability of services that are available to somebody who may live in another part of Durham region.

**Ms Fisher:** I don't understand how that relates to the MSA structure. I don't understand what you're trying to tell me. Are you trying to tell me the government is looking at that area, which it hasn't? I don't understand what your point is, sir.

**Mr O'Connor:** The point here is that not all parts of the province as a whole have been well served in the past in taking a look at all the services that are needed for the consumers of long-term care services. In Durham region, Brock Good Neighbours, up in Brock township, does do a very good job, and I'm sure the people who are involved in not only volunteering or working with that agency are going to be involved with the process that's going to see the change, so the consumers up in that area aren't going to be left in a lurch.

The important thing is that not all communities have received the same level of care that has been made available in parts of the province, and what we have to do is try to take a look at the needs of the consumer right across the province. What we have heard, unfortunately, is that the status quo is fine and we shouldn't really do anything about it. That's not what people have said for a lot of years: "Please don't do anything, please don't change anything. Everything is fine out there as far as the provision of long-term care within the community."

**Ms Fisher:** I think there are different ways of providing services for areas which don't have it. My concern, as a consumer and a stakeholder, is the process that's going to be set up to provide these services. My brief does not say that services needed to stay the way they were. My suggestion is that they be fine-tuned to make the old system work more efficiently.

**The Acting Chair:** Thank you for your presentation. We shall be taking a two-minute recess, or thereabouts, to properly prepare for our next presenters.

*The committee recessed from 1021 to 1026.*

CITIZENS FOR INDEPENDENCE  
IN LIVING AND BREATHING

**The Acting Chair:** I want to extend a welcome to representatives on behalf of the Citizens for Independence in Living and Breathing. Good morning.

**Mrs Margaret Wagner:** Good morning. My name is Margaret Wagner. The three of us, as you know, represent Citizens for Independence in Living and Breathing, which is a nationally incorporated charitable organization which assists ventilator users with neuromuscular disorders through education and information. First of all, we'd like to thank you very much for the opportunity to present our views to this standing committee. It is greatly appreciated.

In our brief, which I believe you have, there is a one-page introduction followed by a summary of key recommendations which we will use as we speak this morning. We will speak to the summary. Following the summary, there is a complete text of our brief, including our recommendations in detail. I will speak briefly to part 1 of the summary, which deals with the bill of rights.

First of all, we are delighted to see a consumers' bill of rights included in the act. We wholeheartedly endorse this. We would, however, like to make it stronger and we have three suggestions to do so.

(1) We support the addition of a clause to the bill of rights which would guarantee the right of access to community services for all consumers who meet eligibility requirements.

(2) While consumers or their agents are given an opportunity to participate fully in the development and revision of their plan of service, we believe this could be strengthened by also being made a right. In addition to the participation of the consumer in development and revision, we would like to see the consumer involved in the evaluation of the plan of service. We are aware that this is not a simple request because it would involve an addition to the bill of rights itself, a change to the definition of "plan of service," and, as well, a change to section 20. So we realize that is not necessarily a simple request, but it's still something that we believe in.

(3) We believe the bill of rights could be considerably strengthened if contravention of any part of the bill of rights was specifically included in the list of reasons stated for revocation or suspension of an agency as listed in part X.

I am now going to turn this over to the real experts who are here with me today, who will discuss the rest of the summary.

**Mr Steve McPherson:** My name is Steve McPherson. I use phrenic pacers for breathing 24 hours a day as a result of a diving accident 12 years ago. I spent nine years in institutions before moving into an SSLU about three and a half years ago.

I will address the first recommendation in part 2, which deals with the combined effects.

We are concerned about limited choices for minority groups such as long-term ventilator users as a result of rationalization by institutions and the development of MSAs. We are aware it is impossible for every MSA to include agencies that provide services for all groups, and there are an estimated 200 to 300 ventilator users in Ontario. Currently, respiratory centres that provide services to ventilator users are also few in number. We are concerned that the numbers will further be reduced as a

result of limiting the centres providing services and that frequently the services provided by centres often reflect the philosophy of those in charge.

Our first recommendation in part 2 describes actions which we believe will maintain the type of services we need.

**Mr Tom Wagner:** My name is Tom Wagner. I have Duchenne muscular dystrophy and I have been a full-time ventilator user for 11½ years. At this point, I can only breathe on my own for less than five minutes. Since being ventilated, I have lived at home with my family, partly by choice and partly because there is no other viable accommodation available to me. Living at home has made it possible for me to complete a bachelor of arts degree at York University.

I will discuss part 2, recommendations 2 and 3.

(2) The act requires that an MSA board reflect the diversity of the persons to be served by the agency. While there is mention of the disabled, there is no mention of consumers. Because disabled persons are not necessarily consumers of the MSA in their area, and because long-term ventilator users will not be able to obtain services at all MSAs, we believe the inclusion of the word "disabled" does not adequately ensure representation of long-term ventilator users on the boards of those MSAs providing services to them.

(3) The act restricts the information provided by any multiservice agency to "information about the services that the agency provides or arranges," and also restricts referrals made by multiservice agencies to "other services available in the geographic area for which the agency is designated." How do consumers who require unique services not available within their own geographic area learn what is available for them? How does a consumer requiring specialized services not available within his or her particular geographic area obtain referral to the appropriate agency in another geographic area?

Our recommendations for resolving these issues are listed on page 2 of the summary.

**Mr McPherson:** In our part 3 we're dealing with attendant care. The first issue is functions of attendant or personal support workers. My part again deals with recommendations 1 to 4 of the summary, which address this issue.

There are four types of services listed in the act, which appear to be mutually exclusive. Currently, attendants provide services mostly from two parts: homemaking services and personal support services. We have three questions, then, that we feel need to be addressed and resolved.

(1) Can services from these two lists, or any of the lists, be combined and performed by one individual? For example, can somebody help me prepare my breakfast in the morning, which would be listed under homemaking, feed me, which would be in the personal support services, and then tidy up? If not, it's going to add a lot of extra time to my care, waiting for an individual to come in and do their part.

(2) Will consumers who choose to arrange attendant services outside of an MSA be restricted if they apply to

an MSA for other services such as shopping, banking etc?

(3) Will attendants or personal support workers be able to use the wording of the act to restrict their activities to those on the list if they should be unionized?

Our recommendations address solutions to these possible problems.

I'll hand it back over to Tom. Confusing, isn't it?

**The Acting Chair:** It's like watching a tennis match.

**Mr Wagner:** Recommendations 5 and 6 in part 3 both concern direct funding. While we acknowledge and endorse the direct funding pilot project currently being undertaken, we recognize in the wording of Bill 101 that this approach is by no means guaranteed past the initial project. Direct funding should be enshrined in the act.

We are concerned that persons who require more than 180 hours of attendant care funding per month are excluded from this pilot. Although I have successfully hired, trained and managed the payrolls of my own attendants for more than 11 years, I am not likely to be accepted for the direct funding pilot project due to this restriction. Our fear is that high-level-care ventilator users could be excluded from direct funding in the future. The only criteria for this method of funding should be the demonstrated ability to effectively manage the system.

**Mr McPherson:** Part 4 is levels of funding and accommodation. I will address our recommendations 1 and 2.

The act is silent on issues of funding for community support. Currently, significant discrepancies exist between the funding available for institutional support of ventilator users and that which is available for community support, and an even larger discrepancy for families providing care at home. This is of particular concern to long-term ventilator users, who frequently require more care than the average person with a disability.

The cost comparisons are pretty up to date. For ICU it's over \$1 million a year. For long-term care and rehab, it's up over \$200,000 a year. Where I live, in the SSLU, it's about \$70,000 a year, and that's including the rent subsidy, the family benefits and everything else that is provided for me.

Home costs are not quite available, usually because unpaid family support makes up for the brunt of what Tom gets. A solution would be to enshrine principles of funding in the act as written in our recommendation 1, and that arbitrary caps be removed to avoid institutionalization if an extra, say, \$10,000 a year provided for the agency where I live would avoid institutionalization, because obviously it's still going to be less expensive than making me move back to West Park Hospital.

1040

**Mr Wagner:** I will discuss part 4, recommendations 3 through 5.

Some conditions which lead to the need for ventilation are progressive, ultimately leading to 24-hour ventilation and the inability of some to breathe unassisted even for a brief period of time, five minutes or less.

Two formulae for funding, referred to as "basic funding level" and "enhanced funding level," have been

proposed. However, there is no mechanism for flexible bridging between these two formulae which would serve the needs of persons with progressive disorders who gradually need increased assistance.

Existing SSLUs in Ontario, to the best of our knowledge, are not designed to provide a rapid enough response time for emergency situations such as accidental disconnection of the tubing. Noble House in Vancouver is a model of suitable housing for high-level care ventilator users, where an emergency response time of 30 seconds has been achieved. The threat of reinstitutionalization remains a grave concern for several CILB members who are ventilator users.

On the other hand, families that care for ventilator users at home have unrealistic expectations placed on them, frequently to the detriment of everyone's health. There are no vacations or weekends off, and sleep disruption for those providing the care is very much the norm. We recommend that respite care include an annual vacation period, occasional weekends and rest several nights per week.

This concludes our presentation this morning.

**Mrs Barbara Sullivan (Halton Centre):** This is a very comprehensive brief and I know that all members of the committee really appreciate it. You've done an enormous amount of work, and we'll want to review it both inside this very short session that we have left as well as after.

If I can just flip through, I couldn't agree with you more on your recommendations with respect to the bill of rights, and we will be putting recommendations forward for amendment with respect to right of access to services by those people who meet eligibility requirements. One of the things we've been deeply concerned about with this bill is that the only right for service that's included is the right to be put on a waiting list. We feel that's not appropriate.

I'm also quite interested in and will want to look at your recommendation that contravention of any portion of the bill of rights would be added to the grounds for which the minister could revoke or suspend approval of an agency. I think it's an interesting one. Whether the revocation or suspension of the agency is the appropriate penalty or whether another penalty would be more appropriate, I think we should look at that quite carefully.

You've raised a number of questions, one of them with respect to the pilot project on the attendant care services. Here it is, on page 12. I did not know that persons who require more than 100 hours of funding at the basic level are excluded from the pilot project. I wonder if we could have a response from the parliamentary assistant or the ministry representative as to why that decision was made. Clearly, there are a number of people who require attendant care for more than that period of time. Why were they not included in the pilot?

**Mr Wessinger:** I'll ask Mr Quirt to reply to that question.

**Mr Quirt:** Our current thinking on the policy for attendant care outreach services delivered by the multiservice agency or by independently funded attendant care

outreach programs—disabled consumers have the choice as to whether they wish to have their attendant care outreach programs continue to be independently funded or whether they wish to access attendant care outreach services from the MSA. The current service limit I understand is 180 hours.

The point is well taken that in the case of some consumers, particularly those who use a ventilator, that 180 hours may not be an adequate upper level in order to provide the degree of emergency response and onsite service that's necessary.

I suspect that the pilot project will be looking at just that issue. We're hoping to learn from the pilot project under what circumstances that upper service level would have to be adjusted to accommodate as many people as possible in either the supportive housing settings that one of our presenters resides in or on an attendant care outreach basis, where the attendant care agency employs attendants to serve disabled consumers, or whether the disabled individual, the person with the disability, employs his own attendant or attendants.

**Mrs Sullivan:** I'm just quite taken aback at that. I did not know that the pilot was limited to the 100 hours. I certainly know of many—

**Mr Wessenger:** He said 180 hours.

**Mrs Sullivan:** No, 100 hours. The pilot is limited to 100 hours. The current rules are 180.

**Mr Wessenger:** I think Mr Quirt indicated that the limit was 180 hours. Is that correct?

**Mr Quirt:** It's my understanding that the limit is 180 hours and the pilot project is limited to 180 hours.

**Mrs Wagner:** The enhanced funding formula still states 180 hours but it suggests care by people with greater preparation and therefore with higher salaries. If you take that money and put it into attendant care, you could come in under that budget by using attendants for the hours required instead of RTs or RNs and so on. We're hoping that will be partly a solution, but it would certainly put the hours over 180.

1050

**Mrs Sullivan:** I apologize for the confusion over the 100 hours.

I'm also very interested in the question that you ask on page 8 with respect to how consumers who require unique services that are not available within their own geographic area receive information about what is available and where, and how those services can be arranged. I think that issue, particular specialized services, does merit an amendment that makes it clear that the MSA's responsibilities go beyond the geographic area. I think we'll all want to look at the wording there.

I'd also like to have a comment from the parliamentary assistant with respect to an issue that you raise on page 11, item 3. The question is, "Will attendants or personal support workers be able to use the wording of the act to restrict their activities to those on the list," should they be unionized? I suppose that really what you're looking at here is a work-to-rule situation or a situation where there is a conflict in a bargaining dispute. I wonder if the ministry representatives could comment on the kinds of

care, the kinds of services, whether it's through an MSA or through other health services, that cannot be withdrawn or limited and what impact the existing law has on people who are receiving care in their homes or in other community settings.

**Mr Wessenger:** I think perhaps the first answer would be that the matter would be determined by the provisions of any collective agreement and not by the act itself. I don't know whether legal counsel could add to that.

**Ms Gail Czukar:** With respect to your first question about what would restrict the activities of the worker, that would be determined by the collective agreement and not the wording of the act. I'm not sure if I heard the last part of your question about the effect of the existing law on services now being provided.

**Mrs Sullivan:** Certainly, we know that health care providers in hospitals and in other long-term care facilities can strike and can withdraw services and so on. What mechanisms are there to ensure that people who are at severe risk are not placed in jeopardy as a result of the withdrawal of services? We know that historically there has been a kind of cooperation, I suppose, usually in those situations in hospitals and facilities, but I don't know that we've been exposed to that kind of work disruption in home care or community services.

**Ms Czukar:** We have had strikes and other labour action in other kinds of services. I guess there would be two mechanisms. One would be the use of the Hospital Labour Disputes Arbitration Act that could be applied to services such as these, or to have them classified as essential services so that arbitration would replace the right to strike. We haven't discussed that at all, but those would be two mechanisms that would ensure that services would carry on in the event of labour disruption for people who absolutely needed them.

**Mrs Sullivan:** Could we just ask that the ministry give some thought to these situations in the community setting?

**The Chair (Mr Charles Beer):** Do you want to comment?

**Mrs Wagner:** I sat on the committee that looked at the education. That's how we are involved in that. If the personal support worker sees a list in the law that says "personal support services," is the personal support worker going to say, "That is my job description or refers to my job description"?

**The Chair:** I think the issue has been raised and the minister will look at that.

As Chair, and I've come in late and I apologize for being late for your presentation, I also at times have to play the heavy, which means I have to say that discussion will have to end because we have other presenters. But I know that on behalf of the committee we want to thank you for coming, and if I may just say, Steve, it's good to see you.

**Mr McPherson:** I love it where I am.

**The Chair:** We wish you all the very best with your work ahead. Thank you for coming before the committee.

## ASSOCIATION OF ONTARIO HEALTH CENTRES

**The Chair:** Our next presenters will be from the Association of Ontario Health Centres.

**Ms Sonny Arrojo:** I'm Sonny Arrojo. I'm the executive director of the Association of Ontario Health Centres. The Association of Ontario Health Centres thanks you for the opportunity to present our position paper on Bill 173. You have a copy of our presentation and some additional information on the association and community health centres. As noted in the information that we have provided, we are the provincial organization of Ontario's community health centres and some health service organizations.

Our member centres provide support to approximately 200,000 Ontarians through programs and services in primary health services, health promotion, illness prevention, counselling, literacy, housing and employment. The activities currently undertaken by CHCs in health promotion, community development and advocacy to other communities are considered to be among those on the cutting edge of innovation and creativity. CHCs provide a variety of services to underserved communities which, due to a variety of barriers which include geographic, cultural and linguistic barriers, need improved access.

You have in the information we have provided the beliefs and principles that are the foundation of what we are as a movement. We believe that equity in health implies equal opportunity to achieve and maintain health, including access to programs and services. It is this belief that guides us in our response to Bill 173.

As such, we believe that passed in its current form, Bill 173 will negatively affect access to programs and services, thus affecting the fundamental resources for health of Ontarians. AOHC generally supports the reform of the long-term care services and the attempt to implement reform through Bill 173. However, we believe that certain sections erode the overall merits of the bill. Our concerns are in the following areas.

The need for an integrated approach to health and social services: Bill 173 outlines service standards for Ontario's long-term care services but fails to incorporate the concept of wellness as a key principle of long-term care reform. For example, part I talks about simplifying and improving access through the continuum of community services, yet part II identifies specific service distinctions, which reinforces a fragmented approach to service delivery.

We firmly believe that an integration of the concept of wellness in the legislative framework of long-term care services would allow service provision to consider not only consumer needs but also consumer capacities for health. This, we believe, would provide a different way of looking at the role of the consumer and would help us develop a truly reformed approach to service delivery.

Because of this, we recommend that part II be amended to provide for an integrated approach to health and social service delivery.

Another concern is the need for stronger community participation. Bill 173 hints at a stronger role for the consumer and the community, but on closer scrutiny its

provisions are rather weak in the implementation of this objective. For example, section 20, in part VII of the bill, provides an opportunity for the clients' participation in their "plan of service," but the section is silent on the role of the community as a whole in the process, other than by representation on the board. A variety of community activities influences the health and social wellbeing of individuals in their communities through partnerships with a variety of community agencies, and as such, the capacity of communities to help themselves must be recognized in the provisions of Bill 173.

Because of this, we recommend that section 20, part VII, be amended to reflect a stronger commitment to community participation.

Our next concern deals with the need for recognition of the value of volunteerism. Bill 173 lacks an appropriate recognition of the value and role of volunteers in long-term service delivery. We believe that communities have the right to service that is respectful, relevant and effective, including the use of local volunteer experience to respond to local needs.

We further believe that any legislation that provides for community service delivery needs to acknowledge and emphasize and support the value of volunteerism. Community service delivery must ensure an appropriate balance between the role of paid and non-paid health providers. Community service that draws upon the experience and expertise gained by volunteers encourages the community to build upon its capacities to help itself.

## 1100

Therefore, we recommend that Bill 173 be amended to acknowledge the key role of volunteers in community service delivery.

We also see the need for recognition of the community agency role in local management. We have serious concerns regarding the prescriptive nature of certain provisions in the legislation. Like any number of services provided to the community, long-term care services can only be truly effective if they not only build on the needs and capacities of communities but acknowledge the legitimate role of community agencies in management at the local level. Government should set the broad parameters for the delivery of long-term care services, but it must not attempt to manage at the local level.

For example, part IX stipulates the appeals process in the event of consumer disagreement with the local MSA's decision regarding access, type and volume of service. The only level of appeal available bypasses the local MSA, the local DHC and goes directly to a provincial appeal board. The appeal process and structure contained in Bill 173 not only take the accountability from the local level, but also eliminate the capacities of local agencies to be responsive in a timely manner.

Another example can be found in section 56, part XI, which stipulates the powers of the Lieutenant Governor in Council to include the governance and management of a number of operational issues within approved agencies. In addition, paragraph 24 indicates that quality management systems would be centrally controlled instead of being the responsibility of the individual MSA.

Another example along these lines can be found in section 62, part X dealing with the functions of the DHC. I'm sure you are aware that laid out in your copies of the legislation. The way it is laid out, in our opinion, confirms the planning and advisory role of district health councils. As written, however, clause (d) allows, should the minister see fit, the assignment of a management role to DHCs.

We have concerns regarding the notion of DHCs being involved in management at the local level. DHCs are designed and resourced as planning and advisory bodies and should not have a management role. We are opposed to layers of management structures which are costly, not necessarily effective and will undermine the authority of local agencies in addressing local needs and concerns.

We therefore recommend that part X and section 56 include a community consultation process prior to the ministerial decision for revocation or takeover. We further recommend that part IX be amended to ensure greater community control and that subsection 62(1) be amended to delete clause 8.1(4)(d).

We're also concerned with the need for a balanced approach to service delivery. Part III of the bill outlines a bill of rights for the consumer but fails to acknowledge the financial context which dictates the extent service delivery can be provided. Consumer rights as noted in Bill 173 readily raise expectations to a level that is not achievable and cannot be ensured by the service provider.

Subsection 3(1) of the bill places a mandatory onus on the service provider to ensure that specific rights and conditions of service delivery are provided to the consumer. The list of conditions set out in this section is directly related to the availability and level of funding.

At the operational level, an unqualified bill of rights could easily even serve as a barrier to a collaborative delivery. As currently written, it undermines the possibility of a true partnership between consumers and providers. This section needs to be amended to provide for a balance between what consumers can and should expect and what providers can reasonably deliver.

We therefore recommend that part III be amended by providing qualifications on the extent of services that can be ensured by the service provider.

Finally, we see a need for flexibility in legislation. We are strongly opposed to an approach that inherently eliminates flexible delivery systems at the local level. Bill 173 stipulates central control. For example, section 13 of the bill states that on the amount an MSA can spend on services to no more than 20%: limits on the purchase of health services, no more than 20%; limits on the purchase of personal support services, no more than 20%; limits on the purchase of professional services, no more than 20%.

The provisions of the bill must be amended to provide for local management of the responsibility and authority needed to respond to the local situation. The capacity of

consumers and providers to develop and implement an appropriate service plan, as they see fit, must not be subsumed by government. We recommend that flexibility be integrated into the provisions of the bill.

In conclusion, we believe that the role of the community needs to be acknowledged and valued in any reform initiative. The bill must be amended to clearly delineate those areas that are controlled locally, those controlled regionally and those controlled at the provincial level. Any model of service delivery used in long-term care services must satisfy broad parameters set by government but flexible enough to adapt to the local situation and preserve those community structures that allow for effective management. Ontario's community health centre model, funded through the community health branch, is an excellent example of such a model. Indeed, where it seems it may fit with the local situation, the CHC may be the best vehicle for MSA designation in that particular area.

On the whole, and at the very least, the reform process must result in improved accessibility, quality of service, cost-effectiveness and improved accountability to the clients, the community and government.

We strongly urge the standing committee on social development to seriously consider our recommendations, which we believe will ensure that the legislative structure and framework for long-term care services provide a balance that would allow both consumers and providers a true partnership in the delivery of services within the context of a provincial framework.

**Mr Jackson:** Thank you for your presentation. I guess I can express on behalf of all the committee members that for those of us who have visited a community health centre, they're quite innovative and wonderful organizations, so we're rather intrigued at how they're going to comfortably fit within this MSA structure.

Before I get into some specifics, do you have some fears that in fact services that you're currently providing would be deemed by the MSA to be more appropriately provided outside of the community health centre? That's my first fundamental question. And if you do have some of those fears, could you give us an example of a kind of a service, because I do know you have quite an integrated, flexible model, you're very much on the leading edge of health promotion, and the bill doesn't really clarify that.

**Ms Arrojado:** We have those fears. I don't know that I can give you a specific example of that because each community health centre has a variety of programs according to the needs of their community. But our main fear is that, if implemented, the process of MSA designation and type of services that will be delivered will fragment the approach to health service delivery that should be integrated at the local level. We see CHCs working closely with an MSA, or acting as an MSA if it makes sense in that particular area, with the objective of ensuring that the approach, a singular comprehensive approach, is available at the local level.

I think, because of our concerns about what reform will look like, not only in long-term care services but in the health system as a whole, our fears are based on lack

of an overall picture, which I guess the community is going to expect in the next few years, if in fact reform does take place, when and if it takes place. That is why any particular threat is something that really worries those communities.

1110

**Mr Jackson:** I know you're speaking for all health service organizations in Ontario, but clearly when we were in northern Ontario, not only when we were doing bill 101 on institutional reform, but also recently, this summer, there were some very strong presentations on health centres in northern Ontario where they were servicing almost as large a model as the potential MSA in terms of geography and in terms of outreach. I think it would be rather inappropriate to disrupt that, since this is being developed in those areas, which is different from, say, downtown Toronto where they may form a portion of an MSA and not in the same catchment area.

Are you aware of any of your organizations which are actively involved in long-term care committees and are looking at making recommendations to the government about integrating the services; in other words, taking all the best elements of a community health centre and applying it to the MSA model? Can you point us in the direction of where this may be occurring somewhere in the province before this becomes law?

**Ms Arrojado:** We have some of the very active community health centres, for example, the Lakeshore Area Multi-Service Project. They've been involved in the subcommittee at the Metro Toronto district health council, and I believe had a report specific to where they see the MSA model would fit into the scheme of things.

There's a group of community health centres in Ottawa that have made, I believe, a representation to this committee concerning where they see the role is for community health centres in terms of integrating a service delivery approach. I think the main concern is that a model is designed provincially and intended to be replicated throughout the province, and in fact is not dealing with the needs at the local level, and in fact is really a very outdated approach to health service delivery.

It is replicating a system that we know to be expensive and not effective and not working with the community to work on their capacity to help themselves. Our concern is that if you only start to focus on needs rather than on the assets of the community, we will develop a system that will be outdated before it's even implemented.

Reform, in our opinion, needs to really change the concepts by which it looks at service delivery. It's not doing to people, but doing with people; not doing for somebody, but doing with somebody. It's very difficult to do this in the lack of a community development approach to reform. There has been a glaring and appalling lack of recognition for the need of community development in terms of any reform initiative, not only in this province, but right across Canada, and it's unfortunate and that's a real critical link. In our opinion, you cannot accomplish reform without that piece.

**The Chair:** Thank you very much for coming before the committee this morning.

MARGARET MYERS

**The Chair:** I call on Mrs Margaret Myers. I note you come from MacTier.

**Mrs Margaret Myers:** I come from a little further than MacTier. That's the post office box I maintain.

**The Chair:** We are pleased that you have been able to come down and meet with us today. We have a copy of your submission before us, so please go ahead.

**Mrs Myers:** Thank you for having me appear here. I'm Margaret Myers. I am a resident of the township of the Archipelago, which is in the district of Parry Sound. I am prefacing my submission with two points:

(1) If the purpose of Bill 173 is, as it appears to be, a serious intent to provide all resident citizens of Ontario with access to community-based long-term care, I am asking this committee to clearly word the legislation identifying the level of government responsible for ensuring conformity with the act, or,

(2) If, as a result of these hearings, this committee decides to adopt a less all-encompassing program that would empower a municipality to fit the legislation to its own particular will, as suggested by Mr Wilson, a member of your committee, I am asking that the wording of the legislation clearly indicate this fact and leave nothing to individual interpretation.

Since the persons to be served by Bill 173 will be at a disadvantage either as to age, physical disability or illness, (1) would eliminate the need for costly litigation to enforce the provisions of the statute, as seems to be required in the case of other municipal services, and (2) would ensure that no misunderstanding could arise resulting in wrong long-term residential decisions on the part of individuals.

The purposes of this act as set out in part I are admirable in the course that has been set to deinstitutionalize our society for a future with an aging population. Congratulations are in order to all concerned for translating farsighted philosophies into a legislative instrument.

The act may possibly be flawed in an area that would probably never occur to the formulators of the policies. That is the area which requires other government agencies at various levels to fulfil what appear to be their statutory obligations in order that the requirements of Bill 173 may be met.

My husband and I, now reaching an age where farsightedness would indicate the possibility of being in need of some of the services provided for in this act, live in a municipality which refuses to fulfil the statutory requirements with regard to winter maintenance of the road under its jurisdiction, the only road access to our home, which is located in an R1 residential zone under the Planning Act, and furthermore will not allow us, under threat of prosecution, to winter-maintain it at our own expense.

This lack of winter-serviced road already denies us ambulance service for up to six months of the year since regulations allow only to the "end of a serviced road" as well as other in-home services already available. It can readily be seen that all future in-home support services in Bill 173 would be similarly affected.

Of much greater concern is the content of part II, "Interpretation," that includes "a municipality" in many of the definitions. This could possibly put an instrument in the hands of a power-wielding municipal council and/or employees, out of concern for their employment, to have residents removed from their home if it, a municipality, is not willing to fulfil the requirements of the act. My husband and I are optimistic of the prospect of not having to need these services but are realistic enough to envision the possibility and what it could mean to us, given the philosophies of the second-home-dominated nature of the municipality in which we live.

The act, to my mind, is meaningless for us unless it has built into it who will enforce the provisions contained. Aspects of the situation with regard to our road are covered in many provincial statutes but it appears that we have to shoulder the burden of bringing the issue before the courts. We are financially and emotionally drained in the attempt to have the levels of government involved assume some of the responsibility. How would we deal with a similar situation with regard to this act, 10 or 20 years from now, together or one of us alone?

The Commission on Planning and Development Reform in Ontario, the Sewell commission, in its final report, Summary and Recommendations: New Planning for Ontario, on page 3 recognizes that cottage country is "one area of Ontario that expects continued growth.... As well, more and more cottages are becoming year-round homes."

I would like to respectfully suggest to this committee that if a municipality zones an area as R1 residential, when there are provisions under the Planning Act to do otherwise, this is an indication that they are promoting year-round dwelling in such areas with the full recognition and acknowledgement of the obligations it imposes and ask that your legislation, Bill 173, provide for this.

Thank you or this opportunity to put my concerns and views forward.

1120

**Ms Carter:** Thank you very much. It's interesting, we've heard from a very large number of people on this committee and yet there's always another angle and I think yours is a new angle that we haven't quite heard before. So I thank you for your general support of the bill and I hope that you and your husband will not need the services, but on the other hand—

**Mrs Myers:** I hope so too.

**Ms Carter:** —you're wise to be concerned, as we all are.

I think what you're concerned about is the structure of how this is going to work and who's going to be responsible. I guess the general picture is that each multiservice agency will have funding, a sort of envelope from the government which they will then spend according to the priorities of that particular organization. They will be self-governing. Each multiservice agency will have a board which will be locally elected by, I guess, interested people who join so that they will be responsible themselves for what they do.

You brought in the municipality, and it is an interest-

ing feature of the legislation that local health units in municipalities are designated as being low on the priority list of those who can become multiservice agencies. We have heard from some presenters who think that's unnecessary and should not be the case and that those agencies should be able to compete at the same level as other organizations to actually be the MSA. You seem to be expressing some fears that that might lead to problems, I guess because you've have problems with your own municipality. Perhaps you could comment further on that angle.

**Mrs Myers:** I have to admit, Ms Carter, that I read through this Bill 173 from beginning to end. I do not have the expertise since I've had no contact in my life with any support services. What I don't see in this bill is any wording that tells me that if this agency—under the definition some of the agencies are the municipality—says, "We are not prepared to do that, Mrs Myers," I have access to enforcement other than what already exists in other legislation in other ministries. It has been my experience that in order to enforce this, because it isn't specifically written into the act and it's covered by different sections of different acts, the only judgement that can be made is by the courts.

What I'm asking you to do is, if your intent is that every citizen have this access, then please have your consultants, your lawyers, whatever, look at it and say, "In this specific instance, how would we deal with it?" I see a situation where there's a three-week period or whatever to do with appeals, but we have been attempting to deal with our own situation for seven years directly. We have had it for nine years.

Authoritative agencies do tend to support one another—and I don't disagree with that. This is the fabric of our society. We can't have one government agency fighting with another. Certainly we can't have the province fighting with its children, its municipalities and back and forth, but by the same token there is no point in wording legislation if you do not build this in in the first place, and I see that flaw.

**Ms Carter:** I think there are some safeguards here; one is that there is an appeals process. As I say, it is locally governed so that you would have access to the relevant board. Also, of course, we have the Advocacy Act kicking in probably early next year. I don't know whether you know about that.

**Mrs Myers:** No.

**Ms Carter:** That means that if you are a vulnerable person—and as you so rightly said, if you need these services, you probably are a vulnerable person in some respect—all you need to do is to call a phone number, which will be displayed in relevant places, and an advocate will come and see you.

**Mrs Myers:** Thank you.

**Ms Carter:** You put your own point of view, your problem. They don't tell you what you ought to do. They listen to you and they take steps to remedy what that problem is, either at the personal level or there's also what we call systemic advocacy, where if it's something that maybe affects a whole number of people because

there's something wrong with the way things are being run or whatever, then that also can be looked at.

But maybe we should ask for an expert opinion as to exactly what the safeguards are. As I say, I think I've mentioned a couple of them, but perhaps we could have an expert opinion on what the safeguards are in this bill.

**The Chair:** Parliamentary assistant.

**Mr Wessenger:** What particular safeguards area are you looking at with respect to the question?

**Ms Carter:** As I say, the presenter is justly worried as to what will happen if we've got all this wonderful stuff in this bill and then somehow it doesn't work for her in her specific situation and what the comeback is.

**Mr Wessenger:** I think the concern that the presenter has raised is with the whole question of access. This bill doesn't really deal with the question of road transport access, and I think that's a matter that has to be dealt with relating to the Ministry of Municipal Affairs. I certainly have great sympathy for the presenter. I was quite interested in her comments that the municipality would not even let her maintain the road itself, because I have a second residence in another municipality, and one of the affluent owners of one of the summer homes maintains it in the winter by having it plowed at his own expense, and it is a public road. This is, by the way, in Muskoka.

**Mrs Myers:** Of course I'm aware, and it's the same in Huntsville. Every other municipality in the district of Parry Sound, of which our municipality is not the largest in population but the largest in mass and also the largest in assessment, allows citizens, under their inspection, to plow the road access to their property. Of course this is understood. We're not expecting the municipality or its taxpayers to absorb the cost; we are quite willing to do it ourselves.

**Mr Wessenger:** But your municipality won't?

**Mrs Myers:** Will not.

**Mr Wessenger:** Will not. I must say I also tend to agree with your position, and I think that legally if a municipality zones an area for full-time residence, under its zoning bylaw it has an obligation to provide access year-round. Probably the courts would find that, but I can understand your frustration.

**Mrs Myers:** I'm sure, but who can shoulder the financial burden?

**Mr Wessenger:** I think the point you've made is that there are impediments to services that governments provide outside of the area, and we ought to be looking at that aspect.

**Mrs Myers:** Exactly.

**Mr Wessenger:** I appreciate your comments in that regard.

**Mrs Myers:** Yes, and not necessarily for ourselves, obviously by the time this gets going, but to ensure that you don't get yourself into a situation that you hadn't foreseen.

**Ms Carter:** But then you would have the multiservice agency presumably on your side, because it would be trying to deliver services to you, and it could go to the

municipality and say, "Well, look, we need to get to these people and we can't."

**Mrs Myers:** Oh, I agree. My concern was that sometimes the municipality may be the agency. That was my understanding of the definition.

**Ms Carter:** Which, as I say, is an interesting light on the fact that municipalities are not seen as the ideal agency.

**Mrs Myers:** I agree 100%.

**The Chair:** I think you have placed a broader issue by using your own specific situation. As Ms Carter said, at times as we get to the end of committee hearings we think we've heard all the different issues that might arise, and then something quite new emerges. We thank you for coming before the committee and making those concerns known to us.

**Mrs Myers:** I hope it has been of some assistance.

1130

VICTORIAN ORDER OF NURSES (ONTARIO):  
DURHAM REGION BRANCH;  
METROPOLITAN TORONTO BRANCH;  
PEEL BRANCH; SIMCOE COUNTY BRANCH;  
YORK REGION BRANCH

**The Chair:** I call on the representatives from the Durham, Metropolitan Toronto, Peel, Simcoe and York region branches of the VON. Welcome to the committee.

**Ms Marg Purkis:** Mr Chairman and members of the committee, we are pleased to appear before you today to present the views of five branches of the Victorian Order of Nurses regarding the government's legislation to establish multiservice agencies. My name is Marg Purkis. I'm a member of the board of VON, Metro Toronto. I am also a past president of the board of VON (Ontario) and am currently a sitting member of the board of directors of VON Canada.

With me today are Phil Curtis from VON, Durham region, president of their board of directors; Charles Style, VON, Simcoe county, board of directors; and Carole Burtch-Rudderham, who is executive director of VON, Peel region.

In 1993-94 our five branches provided almost one million nursing visits and 24,000 volunteer hours of service. We employ 1,100 staff and have 635 volunteers in our combined branches. We provide our services in a culturally sensitive manner and are responsive to diverse ethnic needs. A fact sheet appended to this submission lists the various programs and services we provide in and around the greater Toronto area at our five branches: Durham region, Metro Toronto, Peel region, Simcoe county and York region.

We at VON have long recognized that changes are required in the delivery of long-term care services. We applaud the government's commitment to strengthening the long-term care system and appreciate the hard work that has gone into developing new legislation aimed at improving service delivery. Specifically, we support the purpose and general direction of the act, the inclusion of a proposed bill of rights for persons receiving services, simplified access for the consumer, centralized information and referral, a mandatory quality management sys-

tem, the introduction of appeal mechanisms, a partnership of health and social service providers, the emphasis placed on health promotion and wellbeing, and the improved availability of and eligibility for long-term care services.

We do, however, have a number of specific concerns about that proposed legislation, and I would like at this point to call on Charles Style from our Simcoe branch to begin to outline those to you.

**Mr Charles Style:** Our specific concerns are as follows:

(1) The erosion of our volunteer base: Our five branches are fortunate to have more than 635 volunteers who provide approximately 24,000 hours of service. Our volunteers give freely of their time to govern our activities, fund-raise to support our charitable activities and, finally, provide service to many of our clients.

Our volunteers strongly identify with the VON. The act appears to assume that these volunteers will shift their support to a proposed MSA and, in essence, their role will simply continue under a new service-provider arrangement. We challenge this assumption; I personally, as a volunteer for VON for 15 years, challenge this assumption. We strongly believe that volunteers such as ours will not transfer their loyalty to an MSA.

When the home care program in Metro Toronto attempted to establish a volunteer program some years ago, it found that volunteers were not interested in lending their support to a government agency. A few volunteers might be willing to sit on an MSA board or its committees, but they will not fund-raise on its behalf, nor are they likely to provide much-needed services to clients. If well-established, highly respected organizations such as the VON disappear, so too will many of our volunteers. These volunteers and our established volunteer programs may be lost for ever to the long-term care system and the clients within that system.

(2) Protection for our employees: Although staff in some of our branches are unionized, in others they are not. We understand that unionized employees will have the first opportunity for available jobs in the MSAs. Our chief concern is the continued delivery of quality community care by experienced staff trained in the community, regardless of union affiliation. Non-unionized staff are entitled to fair and equitable treatment under the proposed legislation. Staff who are not currently unionized must be given full protection similar to that offered to unionized employees.

(3) Organizational identity: For many people, community and in-home nursing and the VON are synonymous. Our nurses have operated at the grass roots, shaping our services to meet community needs and providing leadership and innovation in the delivery of community health and health-related services. An intention of the legislation is to streamline the service-delivery system. Such a goal is achievable while retaining the expertise, commitment and resources currently in place. Any change needs to be based upon research and demonstrated results rather than simply for the sake of change. Are you prepared to explain to the public why organizations like VON are being driven out of existence?

(4) Our charitable activities will not be sustainable: At present, the majority of our program revenues come from a fee-for-service arrangement from government contracts. Donations are used to augment these and volunteer programs, to develop new, unfunded services and sustain our charitable work. The infrastructure that we have in place to support our visiting nursing program, along with our volunteers, makes many of these activities possible. However, the new model of service delivery will dismantle this critical mass and make it more difficult to introduce and sustain new services. How will such activity be continued and by whom? Does the government no longer see a need for charitable services in health care?

**Mr Phil Curtis:** (5) Supporting responsiveness to client, not service complacency: The proposed MSA concept includes the direct provision of services, such as nursing, by each MSA. We are not the first group at these hearings to question the wisdom of integrating direct service delivery with other MSA functions, such as referral, coordination and financing. Our concern is that such a model of service delivery will not ensure responsive, cost-effective, quality service delivery. It has been argued that service monopolies invite complacency and tend to be costly and unresponsive to consumer needs.

In Canada, no long-term studies have been conducted to demonstrate the effectiveness of the integrated service delivery model proposed in the new legislation. Moreover, the proposed MSA model has not been subject to any pilot studies in Ontario. The legislation proposes a different way in which to deliver services. We strongly recommend that one or two pilot projects be undertaken and the results evaluated before implementing the MSA concept throughout Ontario.

Consumers should not be expected to take a leap of faith and hope that the proposed new system will offer any significant improvement in service delivery. Structural change in the provision of health and human services requires field testing, evaluation and refinements prior to full implementation. Our branches have the necessary expertise and knowledge and would be pleased to participate in any pilot projects. We have always welcomed the opportunity to be responsive to client needs.

1140

(6) Other impacts on cost and quality: The proposed legislation was designed to reduce the bewildering array of small agencies providing similar services, each with its own overhead costs. The implementation of MSAs will address this concern for some types of services, but the same cannot be said for nursing services.

For example, in Metro Toronto there are currently approximately 20 groups planning for MSAs. Presumably, each will provide nursing services. At present, VON and Saint Elizabeth Visiting Nurses' Association provide a minimum of 90% of the home care nursing within our catchment areas. Will the integration of nursing into approximately 20 MSAs reduce the administrative costs for a nursing program in these MSAs? We think not. In our own experience, a nursing program needs an infrastructure including education and training, supervision,

scheduling, quality management programs and so on. In the present system, the government has nursing service cost data under home care, but costs of the proposed new system are unknown.

In this regard, we support the argument put forward at these hearings by our colleagues from Saint Elizabeth Visiting Nurses' Association. According to their research, if the nursing services provided in Metro Toronto at this time are offered by, say, 20 individual MSAs, additional expenditures of at least \$7 million per year will be required to sustain the current level of service. Does this not defeat the legislation's intention to reduce the current overhead costs of service providers?

This argument also brings us to the issue of quality. Evidence exists to demonstrate the relationship between service volumes and quality outcomes. A precondition for quality care is that sufficient volumes exist to give nursing professionals continued exposure to skilled procedures in order to maintain their competency. Critical mass, therefore, helps to ensure the maintenance and evolution of high standards and practices. Will each MSA have the critical mass to maintain nursing skills?

VON has policies, procedures, standards and quality management initiatives implemented province-wide. Our branches also have a well-developed network to address educational issues, new standards, to share information and design new systems that lead to the improved delivery of care. Will standards be developed and maintained? At a minimum, our five branches expect a total of 25 to 30 MSAs. We believe that the direct provision of nursing services within each MSA will result in higher costs and potential risk to quality and to standards.

(7) De-insuring implied and the potential for a two-tiered system: We understand that the government has proposed the introduction of a funding envelope for each MSA. Each MSA would determine its own spending priorities. The intention to leave budget allocations up to each MSA is particularly troubling. No safeguards or clear guidelines for health and social service allocation have been developed. Without these, waiting lists for some services will grow. Clients whose needs cannot be met because of capping will have to look elsewhere for service. Those who can pay for it will seek other options for service. Those who cannot pay will be out of luck because charitable agencies like VON will no longer have the capacity to provide charitable services to the extent we do now.

At a time when hospitals are shifting more and more of their workload out into the community, there is already a shortfall of dollars to support home care nursing and other health care services. We have been assured that new dollars are going into the long-term care system. Significant funds have already gone into increased support for homemaking, long-term care facilities, placement coordination and all the costs associated with developing the MSA concept. Even more dollars are apparently earmarked for labour adjustments and training. However, more new dollars will be required to create a totally new system. Can we be assured that this structural change is possible, financially feasible and in fact desirable?

Our final concern is the built-in rigidity. The rigidity

of the act, proposing a 20% budgetary limit on purchased services and a four-year horizon, prevents local planning and development of MSAs specific to community needs.

**Ms Purkis:** Our recommendations are as follows:

Build on strengths. We have always been here for the clients we serve when governments are unable or unwilling to provide services. Rather than tearing down or dismantling charitable, not-for-profit community health agencies, build on the strengths of existing health care providers.

Promote more flexible legislation. Eliminate the 20% budgetary limit and the four-year time frame, and thus support local planning.

Focus on functional integration and a partnership model. Focus resources on promoting a partnership of health and social services providers. VON proposes that an appropriate beginning to a multiservice agency be the formation of a partnership of long-term care health and social service community agencies committed to working together towards the stated objectives of long-term care reform. This partnership would include the establishment of an advisory committee that meets the recommended composition of the board of directors as described in the act. This committee would provide the connection between agencies and their respective boards of directors in an advisory rather than in a governing role.

Such a model could ensure effectiveness in terms of cost, service and quality through well-developed management information systems and common data standards. Such a model would build in evaluation, monitoring and measurement on quality management indicators. In evolving such a model and promoting the user-friendly service delivery system, the VON recommends the following:

- First, allocating dollars to the development of an integrated information system with service provider access to a common database.

- Promoting the use of a common client chart.

- Establishing area-wide electronic networks.

- Providing technology such as 1-800 numbers to support consumer access through a single point of entry. As a matter of interest, this is a program that is currently in use in the York region. Carole, perhaps you could just briefly describe how that is in place.

**Ms Carole Burtch-Rudderham:** In York region, they've begun a partnership of community and health services, and it's just an example of how agencies can work together in the community. There's a 1-800 number, and this is located in the home care office. Any agency that receives a phone call for information takes down all the information the client is asking about and faxes this information to the appropriate agency. Then the appropriate agency calls back the client, and in this way the client only has to answer the questions once. All the agencies guarantee that some kind of phone call will be returned to the client within 24 hours.

They also had a small survey done in York region. All the agencies involved, which are Alzheimer's, home care, VON, Community Home Assistance to Seniors, or CHATS, and Red Cross, did this survey over four weeks.

They watched all the incoming calls and asked how many times a certain client had called in for information. They found that 87% only called to one or two other agencies, one or two calls; the other 10% had made more than three calls.

**Ms Purkis:** Our fourth recommendation is that you support real consumer choice. Ensure that consumers are given choices. As providers, we welcome the chance to demonstrate that we can continue to compete in terms of quality, efficiency, cost-effectiveness and client satisfaction.

Identify the cost impact of the proposed system. Prove to Ontario's taxpayers that the proposed model's costs are at least no greater than the existing system. Identify the cost impact of the proposed system.

Protect current community professionals. Ensure that current community-based professionals are given complete and equal access to jobs in the proposed MSAs.

Establish pilot projects and evaluate the results. Establish several pilot projects based on a partnership model of service providers, using a single point of entry for clients in a given geographic area. Using standardized evaluation procedures, assess annually the results in terms of client satisfaction, cost-effectiveness, quality and other key indicators before proceeding with wholesale change.

In conclusion, if we can leave you with one last message, let that be: Make the legislation flexible and adaptable to individual and community needs and resources.

The VON is a 100-year-old national organization. It is a part of the heritage of our community. It symbolizes caring for life. It will be on this government's head if it destroys an institution that has been a leader in the development and delivery of innovative community-based health care and support systems for almost a century. Surely we can work together without destroying an organization that can never be replaced.

We thank you for your time, attention and the opportunity to present.

1150

**Mrs O'Neill:** Thank you so much for coming together, for a thoughtful presentation and indeed, particularly on page 8, a very practical presentation.

You've asked with a great deal of focus some of the same questions as others—you likely know that—requesting a cost analysis, which we don't have on this bill, and I think you know very well the press conference that's being held down the hall at the moment; a request for research, and we haven't got any hard data; and I think you've been most strong in your request for a pilot project and actually offered yourself and ideas to go with that.

There seems to be a real intent here to overlook some of the statistics you've brought forward, such as the 10,000 volunteers, thousands and thousands of volunteers—these are likely not the complete numbers—and the role of charities in health care in this province, which goes back likely more than 125 years, and the complete ignoring of startup costs. I guess that's where I'd like to go.

It's very hard to know what to ask you, because you've got so much in this brief, but I'd like to go to page 7, if I may. Others have brought this to my mind and I don't think we've discussed it very much: the four-year horizon and the effect that's having on your planning in each of your branches; in fact, the effect this bill is having on your ability to plan, which indeed as we all know is a very high contributor to efficiency and effectiveness. Could you say a little bit more about how this bill has affected your planning, whether it be regarding facilities or equipment or indeed the startup of new programs? Then I have one other small, follow-up question, if I may.

**Ms Burtch-Rudderham:** I'd like to answer that question. In our region—I'm in Peel region—and in all of the regions, the long-term care task forces have been given the responsibility to set up individual MSAs specific to the community needs. I believe with this inflexible bill, Bill 173, we can't do that. We can't have local planning. Also, in all of the community consultations where I attended, and I was a facilitator at many, nowhere were they asking for this all-encompassing, monopoly MSA. They were only asking for easy access to program information and easy access to get into the health care system.

You've asked me how this changes our planning in an organization. I must tell you that it's really difficult to even plan for the future. None of us knows what we are doing. I often say it's like living in a Mixmaster and every once in a while a beater hits you and you don't know when it's going to happen next.

**Mrs O'Neill:** Good comparison.

**Ms Burtch-Rudderham:** So it really does involve all of our planning. If you think of transitional costs, I think they've said that a transitional cost for severance may be in the order of \$25 million. Then we have leases on our buildings, leases on our fax machines, all our Bell telephone systems. Everything would have to be assumed. There are many costs in transition that I don't think have been thought about in Bill 173.

**Ms Purkis:** I would also like to add that I think there's an increased cost in resources as well, because as our human resources and certainly our financial resources are being directed so much to this planning and to wondering what we can plan and cannot plan, we are being deprived of the opportunity to carry on with our day-to-day business. We have to funnel so many of our human resources into being aware, being present at individual discussion tables—in Metro alone, 18 separate tables. For Metro VON to be aware of what is going on, to make certain that our presence is there to send that very strong message that we are there to partner, takes away from doing the business we're supposed to be in business to do.

**Mr Jackson:** You're a big agency.

**Ms Purkis:** And we're a large agency, indeed.

**Mrs O'Neill:** And you're likely dealing with the social contract as another beater.

**Ms Purkis:** Oh, definitely.

**Mrs O'Neill:** Now, what about the bottom of page 7? You're the first ones, I think, who have suggested another

structure, so to speak, because as we know, we have the DHCs very involved in the work that you seem to be indicating could be better done or at least done in companionship, and I'm a little confused about how you want to go further.

You just talked about the kinds of meetings you're already engaged in. Where do you see this advisory committee being different from what's happening at the present time? I do know that many people in this province, hundred and hundreds of them, are struggling with how they fit into Bill 173. Where do you see this advisory committee that you describe on the bottom of page 7?

**Ms Burtch-Rudderham:** If I can take you back to Peel region, because that's where I'm from, Red Cross, VON and Saint Elizabeth deliver 95% of the long-term care services now. If you think of an advisory committee, you could have two or three board members from each of the organizations to form an advisory committee, not a governance committee, and they could advise this partnership of agencies how to manage. Over and above the advisory committee would be the elected board that you want in your Bill 173 that would be elected officials in a committee. Does that answer your question?

**Ms O'Neill:** So you don't have a direct relationship with the present DHC structure in mind. It would be more the advisory committee to the MSA boards.

**Ms Burtch-Rudderham:** We were considering that the DHC would be part of the advisory committee, so it would be representatives of the organizations and the DHC long-term care.

**Ms Purkis:** I guess the difference would also be governance as opposed to advisory. Governance is indeed setting policy, something that I think is a growing, learning experience that not everyone is familiar with. It's something that a lot of boards are struggling with at this point.

**Ms O'Neill:** Of course, the role of the DHC is changing so much through this bill and through its present role in long-term care. That is, I think, what I'm trying to clarify in my own mind.

**The Chair:** Thank you very much. I have to look after the long-term care members of the committee, and we're going to have to take a break until we come back at 2 o'clock. We have a long afternoon to complete our hearings. We have had a number of submissions from your colleagues in different VONs, but we do want to thank you in particular for coming before us today with the presentation that you've made.

**Ms Purkis:** Thank you for your time, and I'd also like to acknowledge the large supporting cast that is sitting behind us today. We truly appreciate their presence here today.

*The committee recessed from 1158 to 1410.*

**The Chair:** Just before calling our first presenter of the afternoon, Bob Gardner, would you just note the document that you've circulated to the members?

**Dr Bob Gardner:** You have before you the third edition of the summary of evidence before the committee on Bill 173. This covers most of the briefs, almost all the briefs for the first three weeks. There are a couple that

we're just finalizing and checking. Our plans would be to do that and to include these last two days in the final summary, which we'll get to you next week in good time for your clause-by-clause deliberations.

**The Chair:** Fine, thank you.

#### ONTARIO CHIROPRACTIC ASSOCIATION

**The Chair:** I invite the representatives from the Ontario Chiropractic Association, if they would come forward. Welcome to the committee.

**Dr Bob Haig:** My name is Dr Bob Haig. I'm the director of government affairs for the Ontario Chiropractic Association. Mr David Chapman-Smith is the general counsel of the association. Mr Peter Waite is the executive director of the association.

You have before you a copy of our brief. I'm going to skip over the executive summary. By way of introduction, the OCA represents 1,500, or approximately 90%, of Ontario's 1,700 chiropractors. Chiropractic services are presently not commonly used in long-term care facilities, but this is likely to change. The OCA was not consulted during the development of Bill 173 and today is the association's first opportunity for meaningful comment.

In 1992, the Ministry of Health funded a study to examine the effectiveness and cost-effectiveness of chiropractic management of low back pain. This was performed by prominent health economists and their associates led by Professor Pran Manga from the University of Ottawa. The Manga report, delivered to the minister in August of 1993, contains the following finding and recommendations relative to long-term care.

#### Finding 8:

"In our view, the constellation of the evidence of (a) the effectiveness and cost-effectiveness of chiropractic management of low back pain, (b) the untested, questionable or harmful nature of many current medical therapies, (c) the economic efficiency of chiropractic care for low back pain compared with medical care, (d) the safety of chiropractic care, (e) the higher satisfaction levels expressed by patients of chiropractors together offer an overwhelming case in favour of much greater use of chiropractic services in the management of low back pain."

I have two of Manga's recommendations here.

**Recommendation 1:** "Current policy discourages the utilization of chiropractic services for the management of low back pain. There should be a shift in policy to encourage and to prefer chiropractic services for most patients with low back pain."

**Recommendation 3** reads: "Chiropractic services should be fully integrated into the health care system. Because of the high incidence and cost of low back pain, hospitals, managed care groups (community health centres, comprehensive health organizations, and health service organizations) and long-term care facilities should employ chiropractors on a part-time and/or full-time basis. Additionally, such organizations should be encouraged to refer patients to chiropractors."

In October 1993, the Minister referred the Manga report to the Chiropractic Review Committee, a bipartite committee with representatives of the Ministry of Health

and the OCA which was looking at a wide range of issues relating to access to and funding for chiropractic services. This committee, chaired by former Minister of Health Tom Wells, is about to deliver its report to the minister.

There has at that committee been unanimous agreement on a number of recommendations, including recommendation 7.1, "That opportunities should be available for salaried positions for chiropractors in hospitals and long-term care facilities."

Following an extensive review process over 10 years, a new scheme of regulation of Ontario's health professions was enacted under the Regulated Health Professions Act of 1990. It is clearly important that new legislation that relates to health professional services should recognize the significant changes in delivery of health care services that have taken place over the last 25 years in Ontario and should allow appropriation, evolution and use of existing health care services as defined in the RHPA and its associated legislation.

Specifically with respect to the Long-Term Care Act, the draft provisions relating to health care services failed to recognize the changes that have taken place and are still taking place in Ontario's health care system. The provisions are inappropriate in that they define some services—for example, physiotherapy and speech-pathology services—as mandatory, yet exclude other services that have a potentially important role in long-term care facilities; for example, chiropody, chiropractic, massage therapy and optometry services. Also, secondly, the excluded services cannot be used by a multiservice agency, even on a discretionary or optional basis, without application to and approval from the Minister of Health.

In this submission, the OCA is not asking that chiropractic and other excluded services be included as mandatory services, though a good case could be made for that. However, the OCA does ask that multiservice agencies be entitled to use the services of any regulated health professional if, in their discretion, they feel that this is appropriate and in the best interests of patients. In other words, the act should be more enabling and less prescriptive.

A useful comparison can be drawn with the ongoing reform of the Public Hospitals Act. In the report of the Public Hospitals Act Review Steering Committee, entitled *Into the 21st Century: Ontario Public Hospitals*, is the following:

"The first premise is that the thrust of legislation should be enabling rather than prescriptive. The prescriptive components of the legislation should be directed to ensuring that the responsibilities of the hospital are defined and the hospital board is accountable for fulfilling them. Within this prescriptive framework, the legislation should provide the hospital with freedom and flexibility to organize its response to the needs of the communities it serves as effectively as it can."

Further: "Managing Access to Hospital Resources. Management's strategy for fulfilling the hospitals's mission and social contract should include a clinical human resource plan specifying the mix, number and types of regulated health professionals required in the

staging of their appointments or employment. The Public Hospitals Act should guarantee the right of regulated health professionals to apply for appointment and require the hospital to respond to such applications."

With that general background, I'm going to turn this over to Mr Chapman-Smith to talk about the specifics of our recommendations.

**Mr David Chapman-Smith:** Bob's given you the principle that legislation passed in Ontario today really should be enabling and should be inclusive for all regulated health professions. The practical impact in this case, namely, a joint ministry committee, is about to recommend that chiropractic services should be in long-term care facilities; so it's a practical issue, not just a matter of principle. What I'm going to speak to you briefly now is about how that might be done.

If you look at appendix A, which the association has asked me to draft, first of all, I have the provisions in the current bill and, on the second page, our recommended way of fixing this. I'll just take you through this very quickly.

The way that the Long-Term Care Act is set up at the moment is that you have community services, as you well know, and underneath that you have a number of categories of services, one of which is professional services. Defined in section 2(7), in the definition section at the beginning of the act, are all the professional services. There you see them: nursing, occupational therapy, physiotherapy etc. and number 9 at the bottom, "Services prescribed as professional services." That would be something prescribed by regulation later.

Then, when you look at what services are provided within a multiservice agency, that's provided in section 12, which is divided into mandatory and optional services. The mandatory services, which you see in section 12(1), read, "Subject to sections..., a multiservice agency shall provide or ensure the provision of the following services," and then you have 1, 2, 3, 4, 5. Paragraph 4 is, "The professional services as referred to in paragraphs 1 to 8 of" section 2. The way things are set up, the mandatory services are just described as professional and then you go back to the definition section to see what those are.

Then at the top of the next page, still in the bill as it's drafted at the moment, subsection (2) provides for optional services and says that an MSA "may provide or arrange the provision of" these if the minister authorizes it to do so. Our submission is that it's inappropriate to have legislation today which suggests that some things are mandatory and the others are really not likely to be necessary and you've really got to get a ministerial discretion or fiat if you want to have them.

1420

The suggested amendment, the way round this, is not changing, as Bob has said, in any way the overall intent of the legislation and it's not so intrusive that the chiropractic association is seeking to have the services of its members defined as mandatory; it's just permissive. First of all, in section 2(7), where professional services are described, instead of that section listing the various

types of service, it merely indicates that professional services do include health care services, and then the other three paragraphs are ones that are already in section 2—social work services etc.

Then when you get to the section, namely, section 12, which describes the mandatory and optional services, paragraph 4 would list the professional services there. So you're bringing into section 12 the specific services, which are the same ones that were there before, but the scheme would be necessary to provide for what's in subsection (2). So the defined services are in subsection (1).

Turning to page A3, in subsection 12(2), optional services could be dealt with in this fashion:

"A multiservice agency may provide or arrange the provision of a service not mentioned in subsection (1)"—ie, not mandatory—"if:

"(1) With respect to professional services:

"(a) The service is a health care professional service from a member of a college as defined in the Regulated Health Professions Act;"

That's the one which opens it up to anything. The association is using that terminology because that's the terminology that has already found its way into other legislation; in particular, the association a few weeks ago made a brief to another committee of this Legislature that's looking at Bill 165 to amend the Workers' Compensation Act. That had various provisions referring to physicians only. A number of groups, including the chiropractors and the physiotherapists, and a number of consumer groups, said that was inappropriate, and that has now been changed in clause-by-clause to include this sort of rubric, exactly these words as an inclusive form.

Subsection (1)(b) is really just to capture the things that were already in the bill as already drafted:

"(b) The service is prescribed as a professional service, and the multiservice is authorized to provide or arrange the service, by the minister." All that is doing is capturing provisions that are there already. Then:

"(2) With respect to other services"—these are community services that aren't professional—"services authorized by the minister."

I won't have explained that entirely clearly, but the point is that there's a suggestion for the legislative draftsmen to look at. It's felt by the association that this is practical, that this achieves the principle we're seeking to see in the legislation, without changing the substance at all.

**The Chair:** Thank you. I would just note as well that you have attached to your brief the study dealing with low back pain for our information. We'll go to questions.

**Mr Jackson:** Thank you for a very concise, thoughtful and helpful brief. I wanted to, if we could, give you an opportunity to, by way of example, give us some of the areas of utilization for seniors with respect to chiropractic and how obtaining relief in one secures more independence at home, which I think is the underlying principle around mobility, comfort and ability for seniors and that it's more than simply a medical model because it extends itself to allow for that. Could you give us some

examples of the importance of chiropractic in terms of long-term care, where we're trying not to institutionalize people? I use the chiropractic services but for different reasons. Could you help the committee with a few of those examples?

**Dr Haig:** You've almost answered the question yourself there.

**Mr Jackson:** Well, my mother uses it, but I'll be darned if I'm going to admit she needs long-term care at this point.

**Dr Haig:** In the population of patients who go to chiropractors, the only segment of the population that's overrepresented with respect to the general population is seniors, and there are many seniors who rely on chiropractors for exactly that, for mobility reasons. Now, chiropractors have not traditionally been involved in long-term care facilities, but any chiropractor in the province will have many patients who are able to function better on a daily basis—can get around, can get up and down stairs, for example—because of the treatment that they're receiving, and it is all related to pain and mobility. It's a very common thing.

**Mr Jackson:** Are there any concerns with respect to the fact that there is a fee, a utilization cost, for seniors to utilize your service? Have you thought through as an association the implications for utilization between if you're outside the legislation or within the legislation?

If you're part of the comprehensive team which looks at all aspects of an individual's needs to remain independent in the community, it would strike me as being somewhat wrong if we have one element of that support which is outside, which has a user fee, and forgive me for using that, but there is a contribution after a certain level of utilization for chiropractic in Ontario, that in fact that may compromise the continuum of care or independent living because at some point the senior citizen makes a conscious decision: "Well, I've used up the money that I can use for chiropractic. Therefore I'm going to not use chiropractic and therefore I'm going to put more pressure on other elements of long-term care because I am less mobile."

In my view, that's the biggest fear of keeping chiropractic outside of the circle of collective services that come together to help a senior citizen. This is one component part they just say, "Well, I'm stopped using them because I can't afford them any longer." That's the wrong thing to happen in long-term care reform.

**Mr Chapman-Smith:** If I could answer that, there are two problems: There's the user fee, but there's also the simple fact that chiropractic services are traditionally fee for service. For example, the Long-Term Care Act doesn't cover medical services because those are on a fee for service, and it hasn't traditionally covered things like optometry and chiropractic for the same reason. So there are the twin problems, the overbill and the fee for service.

But what's quite clear in the current reform in the system is that a lot of different providers, and it's anticipated a number of chiropractors, in the future will be moving on to salaried positions in different health care

settings, and I think this gets to the sting of your question. What that means is that this opens the way for a chiropractor to be salaried in this sort of setting and be available to seniors with these needs at no cost.

**Mr Jackson:** I see that as one issue, but I also see this other issue of, as user fees become more prevalent throughout the system, whether it's for home testing, lab testing, for which now there's a user fee that's cropping in, all the way around, where seniors elect to say, "Look, I'll do without that service," I see that doing without chiropractic, for some of my seniors, means they're going to need more services from the long-term care system. Because they've impaired mobility, they now need someone to help them do their grocery shopping. Because they can't have proper leg movement, they can't get on a bus. Therefore, if they can fall under the line to get the definition that they lack the mobility, then they need more expensive types of transportation support.

I see all these as occurring because we failed to bring chiropractic into the bill in a way in which MSAs are structured to look at a holistic approach at how all the senior citizens' needs are covered.

1430

That's the point that's frightening me, that we're not including you in this regard, because the capitation approaches and all those other things are different issues, which I don't know if we want to get into right at the moment. But it's that kind of concern I have for seniors. I don't see anybody advocating that we take that complete approach, and if we're going to do that, why are you outside of that? It's an open-ended question.

**The Chair:** It can have multiple answers.

**Mr Jackson:** One would do.

**Mr Chapman-Smith:** Well, I'm not quite sure what to say to that. I mean, I hear your comment. There are so many issues that arise out that.

What I've been thinking of as you're speaking is the whole wider funding issue for chiropractic services in the province, which has been subject to a lot of debate at the moment, but its practical impact, felt particularly by seniors, is that whereas a few years ago the overbill was about \$1, although chiropractic fees have remained well within the inflation index, over the period the cost is now like about \$17 or \$18 a treatment out of the pocket, and that particularly hits elderly people. So there are wider funding issues in many areas which are making it difficult for seniors.

**Mr Jackson:** Well, I think I've made my point. I hope we're not penny wise and pound foolish with this, for the simple reason that a lot of our seniors are utilizing chiropractic so they can live independently of institutions. I'm surprised that this late in the hearing process—and I lament and apologize that chiropractic was not consulted more directly up front in this process, and to whatever government ministry wants to respond as to why that happened, I can let them explain that, but I'm sorry it did not occur, because I see you as part of the wellness continuum.

**The Chair:** Thank you very much. I have to note that we've been trying to get as many presenters in as possible

and there are more questions but we'll have to move on.

#### ASSOCIATION OF COMMUNITY INFORMATION CENTRES IN ONTARIO

**The Chair:** I call on the representatives from the Association of Community Information Centres in Ontario. Welcome to the committee.

**Ms Carol Jones-Simmons:** I'll introduce us. My name is Carol Jones-Simmons. I am the membership development coordinator for the Association of Community Information Centres in Ontario, and this is Monica Stewart, our association vice-president and the executive director of the Kingston District Community Information Centre.

We'll spend a little bit of time introducing who we are and what we do, because we feel we are not a very well understood service and it relates to our presentation, and then we'll go into the four major concerns that we have with Bill 173. You have our position paper on equitable access, and we've also included a directory on community information centres in Ontario for the use of committee members for your information.

The Association of Community Information Centres is an umbrella organization representing 70 community information centres in Ontario. Our vision is that all Ontarians should have equitable access to human services information, and by human services information we mean social services and health services. As an association we provide leadership to our member centres in the area of standards of service delivery, professional development, marketing initiatives and information technology.

One of our major accomplishments in the last several years, through the assistance of a Trillium Foundation grant, was to develop an automated network of community information centres that collect similar data and share data across Ontario. We believe in partnerships and working with governments and other service providers and consumers to improve access to services, and we have been working diligently in the area of long-term care and community support services.

I'll turn now to Monica Stewart to give you a little background on community information centres.

**Ms Monica Stewart:** I'm the executive director of the community information centre in the Kingston district, and as such I guess I'm well placed to tell you a little bit about what community information centres mean to their communities, for those of you who might not be familiar with the CIC in your own community.

What we do best is match people with services, and we have over 30 years of experiences in linking people to a complex human service system that is changing greatly over time. We help not only the consumers but also the service providers to navigate this complex system.

In 1993, CICs across the province of Ontario handled over 860,000 inquiries from people who don't know where to turn. Community information centres have adapted their services to multilingual communities, the elderly, the physically disabled and, through 24-hour access here in Metro Toronto, to the particular needs of a large urban community.

CICs are also the only organizations in the community whose primary mandate is information and referral. They know the complexities of the system and they have developed expertise in a number of areas. Most of them provide a publications program, referred to as community directories; they provide training to their own staff and other service providers on how to navigate the system; they provide data management for their own large community information databases; and they also report on trends and gaps to other community agencies.

Each community information centre collects, maintains and updates a comprehensive database of non-profit community services and government service information, and the breadth and the depth of these CIC databases are unparalleled in their catchment areas. CICs are partners with the United Way, local and regional municipalities, government ministries in the provincial government such as Culture, Tourism and Recreation, Community and Social Services, Education and Training, Health and Citizenship, and within the federal government such agencies as Human Resources Development Canada. Also, in addition to this, community information centres have the services of about 1,200 to 1,400 volunteers who help out on a regular basis with information and referral services that we provide.

I'd like to tell you just very briefly and point out to you that in our brief we have given you a story of the type of information we provide to people who contact us, and you can look at this at your leisure, because we often find that it's difficult to explain to people the breadth of the type of service we provide within the centres. That's on page 3 of the brief.

**Ms Jones-Simmons:** With respect to Bill 173, there are many things we support, actually, in terms of the government's initiative in this area. We support the fact that there are alternative models for an MSA coming out of the local planning process, and we support that consumer needs ought to be a primary criterion for determining services. We believe that consumers should have choice, they should have quality standards in services, they should have equitable access and they should have an efficiently managed system. We feel there are some concerns, though—we have four of them—that may jeopardize having those two major points of our support not being implemented.

With respect to section 1, the purposes of the act, we feel that consumer needs ought to be the top priority for determining access to services, not rules and eligibility criteria. We feel there may be a lot of people who will fall through the gaps who will not be connected to a multiservice agency without some sort of assistance through a community information and referral type of service. We have made some recommendations on changing the wording of three sections from section 1 to emphasize the primacy of consumer needs as the major criterion in determining access.

A second part of the purpose refers to another belief, that we feel there are many strengths in the current system that could be used to build a foundation for an improved system, that it is not necessary to reinvent services. Necessarily, they may need to be improved or

integrated, but they do not need to be reinvented at great cost. So we have added some wording to clause 1(f) to emphasize that existing community services, where there are strengths in them, ought to be utilized in developing a new system.

I'll turn to Monica to give you some background on the way we feel information referral hasn't been adequately dealt with in sections 14 and 20.

**1440**

**Ms Stewart:** I'd like to address our third concern, which is that there is not adequate coverage at this point in the act of information and referral services. We understand that information referral is to be a major component of the multiservice agency, and we feel that that needs to be expressed in the act more clearly. Therefore, we are recommending the following amendments.

In subsection 14(2), to add to the existing section a sentence, "and other service providers if the consumer's needs can be met appropriately by them." That's on page 6 of our brief. What we mean by this is that in an instance where you have a person who is not referred within the multiservice agency system or to a service that is linked to the MSA, you would still give that person some sort of information that would assist them if it's available within the community.

We also feel that there should be a definition of the word "referral" added in this particular section, and we would like to see referral defined as something that includes the liaison with the person until a connection to an existing service is made.

We also would like to see something in the legislation that provides for those consumers who contact the MSA and are not within the purview of the MSA in terms of eligibility, and we recommend that section 20 be amended as follows: It says in there, "When a person applies to an approved agency for any of the community services that the agency provides or arranges, the agency shall," and we recommend that we add, "(d) for each person who is deemed not to be eligible, ensure that the person is linked with a community information and referral service." Again, that harkens back to the whole intent of the act, that you don't want people falling between the gaps, as they are now, and this is something that is missing here. What happens to the person who actually did not fall within the mandate of the multiservice agency?

In addition to that, we would like to see an amendment to subsection 56(1), which deals with the regulations, by adding something that would create awareness of the existing community information services that are represented by this association and a recognition that information centres or information services are now in existence that hold a vital part that will assist the MSA to make the service that much better for the end consumer and make the access to long-term care services easier for everyone.

We are recommending that the following be added:

"43 requiring multiservice agencies to incorporate existing community information and referral services within an overall plan of information and referral services

for long-term care and support services in the local community."

**Ms Jones-Simmons:** In conclusion, I want to stress that the association works in partnerships with other service providers and with consumers and with government, we hope, in trying to improve the long-term care system, that we commend government for supporting community services and for encouraging the local planning process, but we do feel that changes are necessary in order to ensure the best possible system is developed for Ontario residents.

**Ms Carter:** Thank you for your presentation. I think we'd all agree that information is absolutely crucial to this whole enterprise, and I know we have had presenters who have emphasized that side of it, that we're going to have to make use of technological possibilities to have everything running smoothly and give the best possible service.

But, to me, this is the point: I feel that we're not abolishing what's there and starting again; we're building on what's there and trying to bring it closer together, and of course one of the main reasons why we're doing that in this bill is to gain efficiency and better communications. Obviously, the service coordination aspect is one of the main things about the MSAs; you know, that people will be able to make this one telephone call and get a response from somebody who has available to them all the relevant information. So I kind of feel that that is built in as a very important and basic part of what we're doing in this bill.

I'm sure you will have in your databases a lot of information that would be useful or whatever, so whether you would be integrated or you would hand over that information or what, I'm not quite sure. But the idea that people are going to be left dangling I hope and believe is not going to be the case. Somebody might phone in with a very simple request like, "I need Meals on Wheels," and hopefully the relevant arm of the agency can be contacted immediately and that person would get the Meals on Wheels, I hope, the next day.

But very often requirements are going to be complex. As I say, a main part of this system is that there will then be assessment of the person to find out exactly what they need, with the person's wishes taken into account as to what services they would prefer to receive. Obviously basic to that is going to be to have information of everything that could possibly be relevant, and that would include accessing services in a different geographical area. Maybe the person has an ethnic background and wants to go to a service that reflects that or whatever. So I feel that's there and I don't know what I can do here: just reassure you or ask for your comments on what I've said or whatever.

**Ms Stewart:** Perhaps I could just respond to that briefly. I believe that you think it's there. It's very obvious from your comments. We also believe it's there, but we don't believe it's there uniformly across the province. There are proposals going in right now from Kingston, Windsor, from London I believe, from Hamilton and Ottawa that address these kinds of integration issues, making sure that everybody works together. What we

really feel strongly about is that this be something that is put into the legislation so that we make absolutely sure that it's happening everywhere, and not just in those communities where people like yourselves are very aware of these types of services.

**Ms Carter:** I guess again that's part of the object of the act, to make sure that services which are maybe functioning very well in some areas are available to everybody across the province. I think we're all well aware that at the moment that's not the case, that some areas are well served, some have one service and maybe somewhere else has a different service but not that one, and so on. We want everything to be available. But certainly the information base is going to be absolutely crucial to every multiservice agency, not just for their own area but for the whole provincial picture as to what's available to their clients.

**Ms Jones-Simmons:** I think it's just that we wanted to be sure there was some recognition that there are lots of things we can offer to this process. I mean, in not all cases across the province has it been easy for us to make that case. I think it's been happening in some communities faster than others, but we feel in some cases it hasn't been happening very easily at all.

**Ms Carter:** I'm certainly well aware of my own local branch of your organization. Marilyn Huels is in touch with me and I've been there and found out what they do, which is obviously very valuable.

**The Chair:** Thank you very much for coming before the committee and providing us with information about the centres, and also the profiles, which is always helpful.

1450

PAMELA GRAY

**The Chair:** I call on our next presenter, Pamela Gray. Welcome to the committee. We have a copy of your presentation, so please go ahead.

**Ms Pamela Gray:** I want to start out at the outset by saying that I come today as a private citizen and I come today as a nurse working in the long-term care area but I do not represent a particular agency with my comments. I am coming before you today to inform you of what has happened to me in the past, in the hope that you may understand my genuine fears for my future.

Over two years ago, I lost my position with a volunteer agency as a nurse case manager because of a severe shortage of voluntary donations to this agency. The downturn in givings was triggered by the serious decline in the economy. It took me 10 months to find my present position with a community provider of health care service.

I see the changes to the present health care system legislation as a significant threat to the employment of thousands of nurses, home health workers, occupational and speech therapists and physiotherapists. Nurses within the agencies who act as supervisors of care and middle managers will also lose their jobs.

There are no guarantees that the new MSAs will be able to employ all these skilled workers. Hospitals will not be an alternative source of employment for this group, as funding to institutions is now severely

restricted. This significant disruption to long-term health care delivery is really an assault against the skilled women of this province who carry the daily burden of providing quality health care to seniors and the disabled in Ontario.

Will this government be willing to provide support and retraining to any class of worker displaced by this legislation, including those at a higher skill level? The process to do this must be in place before the legislation is passed.

The agency for which I work will not have enough work to make it financially feasible to continue its operation. Though our government homemaking hours constitute 43% of our business, our private business cannot make up for that loss if we lose the ability to serve our clients. Our clients have very vocally made it known to us that they desire consistency in the provision of their home support hours. They have demanded the same agency and the same worker again and again. This new legislation removes their ability to have any choice in the provision of their own personal care. Right now, if a consumer or her family does not like the care provided by one agency, they can call another. No such choice will be available to clients after this bill is passed.

In Durham region, I have been attending meetings of the long-term care committee of the district health council. At our last meeting, on September 20, 1994, we drew a number of conclusions about our present system. Of special significance was the determination that our present system lacks the ability to share information between agencies about the same client. Presently, each agency must question the client separately about his or her health status and significant problems. An integrated assessment form would relieve pressure on the client to provide the same information over and over again. This better information system could go a long way to diminishing the duplication that now may exist in provision of long-term care. This is but one measure that could be taken to improve our long-term health care system without resorting to drastic legislative measures.

I truly believe the components for excellent health care for seniors and the disabled already exist. Let's find a way together to inform the public of the services already available before drastically changing the system, and please do not make the changes on the backs of skilled and educated women like myself who will have no place to turn for another job.

Finally, I recommend that section 13 of Bill 173 be removed.

**Mr Dalton McGuinty (Ottawa South):** Thank you, Ms Gray, for your presentation. We've heard from a variety of organizations here on behalf of their respective memberships, and it's good to hear from individuals from time to time. That's not to belittle the other presentations or presenters, but it's just good to hear from individuals who will be directly affected by the legislation we're considering.

You raise some very good questions about your prospects for future employment should Bill 173 become law. After all, as my kids tell me, this is the 1990s, and in an employment context the mid-1990s in Ontario are

difficult times. But I believe they are particularly difficult for nurses. There aren't a lot of jobs there.

I am going to allow the parliamentary assistant the opportunity to respond to one of the questions you've raised. I'm going to rephrase it, and if I haven't phrased it correctly, then you can address that. To the parliamentary assistant, what solace can you provide Ms Gray with respect to her future prospects for employment should she lose her job? What compensation will there be, what retraining will there be, things of that nature?

**Mr Wessenger:** First of all, I think I should make it clear that it's certainly the opinion that those people who are delivering services directly are not likely to lose their employment. I think the concern expressed here was with someone at the middle management level, and that is obviously a legitimate concern. What I could tell Ms Gray is that the other day we had HSTAP before us, who indicated that they had been given responsibility for dealing with the situation with respect to any job losses in the community sector, as well as continuing their responsibilities for job losses in the health sector in general. So, yes, HSTAP will have this responsibility.

The other question that was asked was, what about the client/care giver relationship? Certainly it's the opinion that in the move to the MSA, one of the principles should be that there should not be a disruption of the relationship between the person giving the care and the client. It's certainly the intention to try to integrate people in the community, whoever their employer is, into employment with the MSA.

**Mrs O'Neill:** Mr Chairman, could I please clarify something? I have a lot of difficulty with what Mr Wessenger has just said about HSTAP, because they came here and presented to us and asked to be involved in the process. They said they were very willing to be involved but had not to this point been consulted. Are you suggesting now that they are really involved in this? Because that was not the impression they gave us yesterday morning.

**Mr Wessenger:** If I might just clarify, I think the point HSTAP made is that although they had the responsibility for dealing with any job losses in this area, they wanted to be involved in developing guidelines for a human resources plan with respect to dealing with the MSA situation, and they were asking to be involved in the development of the guidelines that are going to be given to individual MSAs, which the ministry is presently working on.

**Mr McGuinty:** Ms Gray, I appreciated your point as well about how what we should be doing is capitalizing on the existing strengths that are found within the long-term care system in Ontario today. It's my view that government ought to be acting complementary to or supplementing what is found out in the community, and not attempting to supplant it or replace it. You join a long line of critics who have rendered severe judgements on Bill 173. We have heard from folks like the Red Cross, Victorian Order of Nurses, Saint Elizabeth Visiting Nurses' Association of Ontario. Any moment now I'm expecting Mother Teresa to walk in that door and lodge complaints about Bill 173.

It's not too late yet. Let's hope the government is still considering this. Thanks for coming up.

**Ms Gray:** May I make one further comment? It is my understanding from what Mr Wessenger has just said that HSTAP is involved with the redeployment of laid-off hospital workers, and it was not my understanding that that would extend to community people as well. Is that now going to be extended to the community system?

**Mr Wessenger:** I understand it will be extended to the community system. That's certainly what HSTAP said to us when they presented the other day. I might, just for clarification, indicate that they have been involved in the development of guidelines. I think what they were asking for is to ensure they continue to be involved, and perhaps in setting up the system.

1500

CANADIAN UNION OF PUBLIC EMPLOYEES,  
ONTARIO DIVISION

**The Chair:** I call on the representatives from the Canadian Union of Public Employees, Ontario division. Welcome to the committee.

**Mr Sid Ryan:** My name is Sid Ryan. I am the president of CUPE Ontario. Donna Powell is a member of our health care workers' committee. Margaret Evans is a CUPE researcher.

Many CUPE workers in Ontario are front-line health and social services workers in hospitals, long-term care facilities, municipalities, public health units and community social service agencies. On behalf of CUPE members as consumers, providers and taxpayers, the Ontario division welcomes this opportunity to make a presentation to the social development committee on Bill 173.

We are very pleased that the government is putting forward the legislative framework which will provide for one-stop access to long-term care services. Streamlining community health services under the umbrella of multiservice agencies will reduce waste and enhance access. Our support, however, is not without reservation. While we support the concept of adequately funded multiservice agencies directly providing core services, there are serious weaknesses in the bill which need to be addressed. I only have a short time today to give you an abbreviated version of some of our concerns. For a full explanation of our position, I urge you to read our brief.

On the question of governance, we cannot accept that workers do not have a legitimate right nor place on the boards of directors of publicly funded health institutions. Their knowledge, experience and judgements are invaluable to other board members who may not be so closely involved with the services being provided and with the persons receiving those services. Two of our recommendations on governance are, in abbreviated form once again:

(1) That section 2 of the bill should be amended to provide for a mix of appointed and elected representatives based on the Quebec model for CLSCs and other health and social service facilities.

(2) That labour should be able to nominate the labour names to district health councils through a joint OFL-ONA nominating committee.

I must reiterate that for our complete recommendations, please refer to our brief.

**Direct provision of services:** We are pleased that the government listened to critics of its first long-term care strategy paper. The government changed its direction and proposed instead a model where brokering between consumers and providers of services would be the exception, not the rule. We were therefore very disappointed to see that section 13 of the bill weakens this commitment. It allows up to 20% of services to be contracted out. Allowing agency resources to be contracted undermines one of the five stated objectives of Bill 173, namely, that of achieving consistency in the system and improving accountability, and threatens the future job security of multiservice agency employees.

One of our three recommendations in this area is that Bill 173 should enshrine the preference for non-profit agencies and stipulate that where services are available from non-profit agencies, MSAs should provide such agencies with the opportunity to provide such services prior to purchasing them from a for-profit agency.

**Consumers' rights:** The inclusion of section 3, a bill of rights, in Bill 173 is laudable and we agree with the principles and rights which are enshrined in that section.

Are people to have the right to the community services they need in Ontario, or are they to have the right to go on a waiting list? Will the appeal board dismiss an appeal of denial of services if an agency can demonstrate that a person in need of a service has been placed on a waiting list?

One of our recommendations in this area is that Bill 173 should enshrine the right of persons to any professional personal support, homemaking and other community support services which are necessary to enable them to live independently in their own home and in other community settings in dignity and with security.

**Designation of multiservice agencies:** It seems the Ministry of Health intends that municipalities and boards of health can only be multiservice agencies of last resort. Municipalities and boards of health have years of experience in administering, delivering and being accountable for a number of services which will, in the future, be delivered by multiservice agencies. We do not believe it is in anyone's interest to lose such valuable expertise and experience.

We would recommend, among others, to delete from Bill 173 subsection 11(3), which makes municipalities and boards of health multiservice agencies of last resort.

**Quality management:** CUPE has had extensive experience with quality management programs like total quality management, continuous quality improvement, patient-focused care and system re-engineering. These programs are being sold to employers as ways to assist them in increasing productivity, at the same time as cutting labour costs, without sacrificing acceptability in terms of quality of the service being provided. The idea is to constantly find cheaper and quicker ways of providing the service. At the end of the day, workers are being asked to do more in less time, creating workload stress and health and safety and burnout problems.

We would recommend that subsection 52(1) of the bill, which exempts records dealing with quality management activities or quality improvement activities from the inspection provisions of the act, be amended to delete this exemption.

**Volunteers:** CUPE recognizes the valuable contribution volunteers have had to make our health care system work. However, we are very alarmed at what apparently seems to be a definitive shift in government policy towards the increased use of volunteers in the health care field. We do not agree that volunteers should be performing the work of bargaining unit members.

One of our recommendations in this area is that subsection 56(11) of the bill should be amended to clarify that any plan for the use of volunteers should be restricted to activities not usually performed by members of bargaining units of unions which represent health and social service workers.

**User fees:** CUPE does not support user fees. We would like to see a lot more discussion on whether user fees are appropriate. The government should release a discussion paper on the subject and conduct further consultations.

We would recommend that the standing committee on social development urge the government to make a commitment that before any regulations are made which would permit the charging of user fees for homemaking or community services, a discussion paper on the subject will be released and further public consultations will be conducted.

**Fair wages and employment security:** CUPE and other unions representing health care workers have repeatedly called upon the government to initiate a process for a province-wide employment security agreement for health care workers to help deal with health care restructuring. A comprehensive employment security agreement must involve an effective and enforceable redeployment system to be administered by the health sector training and adjustment program, HSTAP.

One of our recommendations: that the standing committee on social development urge the government to initiate a process for a province-wide employment security agreement.

In conclusion, the Ontario division of CUPE supports the logic of consolidating existing services for long-term care and the creation of multiservice agencies which directly provide in-home and other community support services.

While giving our support to the overall objectives of the bill, we've explained some of our reservations on a number of key aspects. We hope the standing committee on social development will take our concerns into consideration during its deliberations. Thank you for giving us this opportunity to present our brief today.

1510

**The Chair:** Thank you very much. I will just underline as well that there are other recommendations which you weren't able to underline, but those are all summarized at the end of your brief and we'll certainly look at those.

**Mr Jackson:** Thank you, Mr Ryan, for your presenta-

tion. There is a lot more content in your brief and you had to run through it as you forewarned us, and I had a little bit of difficulty keeping up, but you have a very fulsome report here which some of us will have to have a more extended look at.

The one that comes up on the page that I was on at the time was the issue of volunteers. Could you help me? By way of example, you used the notion in your recommendation 14 that "volunteers should be restricted to activities not usually performed by members of bargaining units of unions which represent health and social service workers." Have you got a couple of examples you could share with us? This whole sector is a patchwork between certified, uncertified and volunteer workers all doing different things but sometimes similar things. Have you got any examples that you could share with us?

**Mr Ryan:** Certainly. One area where we would not want volunteers getting into is obviously the hands-on personal care, which clearly is within the jurisdiction and the mandate, I guess, of the bargaining unit members who work in our long-term care facilities and other agencies. Where we would see a role for volunteers would be in the recreational elements of the long-term care program.

It's no secret that patients in long-term care facilities, because of cutbacks in government funding from all levels of government—not just from provincial governments; we have it at the federal as well as municipal levels—we're finding that the patients are being left sometimes in the corridors on their own with nobody to speak to, no compassion whatsoever. Compassion has gone out of our long-term care facilities. We used to, as front-line providers, be able to spend some time and talk with the patients and help them, I guess, overcome the feeling of loneliness. That's missing from the health care field these days. We see a role there for volunteers. We don't see a role coming in, for example, to help bathe or to feed or to do the hands-on care that we would provide in those facilities.

**Mr Jackson:** That's the question I was getting at, was examples where if you were to go to, say, Kingston, this service is being provided by an organized worker, but if you go to Woodstock, it's being provided by a volunteer. Can you share with the committee any specific examples? You've answered my question, but it was in general terms and—just help direct us to examples of that. Are there cases of people being paid to do Meals on Wheels when it is extensively being done by volunteers, and do we anticipate Meals on Wheels continuing strictly on a volunteer basis, or—

**Mr Ryan:** I brought Donna Powell with me and Donna actually is director of volunteers in her home, so perhaps she can answer that question better than I could.

**Ms Donna Powell:** Meals on Wheels is done in our particular area by Red Cross. It is usually a volunteer, but they don't have direct contact with the residents. That's more into the community. In the homes, volunteers in our particular institution do one-on-one visiting. They help staff in recreational services doing programming. For volunteers to do direct care—you're talking feeding and bathing and things like that—there is an element there that—for instance, in feeding, people who have to be fed

are potential chokers. I myself have been in the nursing aspect of it and it's quite an ordeal if somebody does start to choke.

**Mr Jackson:** I'm not challenging the need for professional services for those scenarios; I was just trying to determine—

**Ms Powell:** I know what you're saying, but volunteers shouldn't really be put in that position.

**Mr Jackson:** Okay.

**Ms Powell:** It's a very frightening experience. I don't think most volunteers would like to be in that position and I don't think it's up to us to put them in that position.

**Mr Jackson:** Could I ask some questions, then, around the issue of the displacement of workers? We've heard a lot from groups around that issue and to the extent that you've had discussions with the government around the re-employment prospects and/or the severance packages for—within Red Cross or within VON or within Saint Elizabeth there are some that are bargaining units and some that are non-bargaining units.

Have you had any discussions in detail you can share with this committee about options in the regs or in government follow-up to this legislation regarding job security, but then, more importantly, rehiring provisions? Is there a hierarchy being recommended? Could you help enlighten us with that? Because your report talks about that they should be protected, but we're proceeding with this and we should have something in legislation and/or there should be some dialogue with the government going on now. You do represent some of these workers, some of whom may be displaced or will be displaced.

**Mr Ryan:** Sure. We're dealing with that very question. First off, let me say there are a lot of misconceptions about what the unions mean by "employment security." Employment security is not job security. We would like job security; we'd like to have a job guarantee for life, but we know that's not the reality in the 1990s, so the next best thing we can get is an employment security agreement, which basically states that if you're laid off in a nursing home—and I'll just take an example of a nursing home at the west end of the city—and they're hiring in a nursing home at the east end of the city, it makes an awful lot of sense for us to retain the skills within the system.

Instead of going to the streets and hiring a person off the street and having to put money into training those individuals to come up to be able to provide the care in the home at the east end, we're saying, let's have a registry, preferably inside of the HSTAP program. Laid-off workers would be registered. When a vacancy occurs somewhere in the system, we would then go to that list of qualified workers, take that worker out and place them in the new vacancy, thereby utilizing the skills and keeping the skills within the health care field. That's what employment security means. A lot of people misunderstand that to say we want guaranteed job security. We don't.

Some complications: What happens if a person who is laid off in a non-union nursing home, for example,

applies for the job? Where do they fit into the system? Those problems have yet to be worked out, but we're working on them. In terms of discussions with the government, we did have a discussion a long time ago, several months back, in the health care field, primarily around hospitals. It hasn't gotten to a point where we're satisfied with it, so we've tried to open up discussions with the government on a broader scale dealing with employment security across all sectors—in other words, the same things for school boards, municipalities—and they're in the very early stages.

**Mr Jackson:** But in this legislation in particular, you recommend that the 20% purchase-of-service agreement threshold should be reduced to 10%. Without getting into the issue of hospice and commercial versus not-for-profit, we don't agree on that point so there's no sense us debating it and you're entitled to your strong views in that.

But I do, however, want to get an understanding from you if you're aware that by asking for the threshold to drop from 20% down to 10% it further compounds worker displacement, because that will mean more agencies will have less access to participate and therefore whole organizations will be told, "Look, they won't buy our service, so therefore we have to lay you off, but they're hiring," because they're now an MSA, a whole new entity which is going to be hiring or providing 80% of it as direct service and only 20% would be—so a unionized worker at Red Cross is going to get laid off because they're an insufficient amount of the 20% of an MSA's capacity to purchase services.

I don't mean to suggest you're running against each other on this. You may have some other reasons for why you want the 20% threshold dropped to 10%, but it further compounds worker displacement which, whether a worker is unionized or not, they're still a worker in this province and they shouldn't necessarily be displaced in these large numbers, as we're expecting may occur.

So could you comment on directly the displacement of those kinds of workers—and not the nursing home example, because they're not really affected by this legislation.

**Mr Ryan:** First off, I disagree with the premise that we're talking about the displacement of workers. If the MSAs are simply an opportunity to bring underneath one umbrella or one-stop shopping, if you will, all of the services that currently are provided within the community, I cannot see how we're going to see job dislocation.

What I do see is a difference between, is it delivered in the not-for-profit sector versus the for-profit sector. I believe the same number of jobs should still exist; I believe those people who are working currently in the for-profit sector and the agencies will have the opportunity to move across into the MSAs as those MSAs are up and running. I believe that the figure of 20% is an arbitrary figure. I don't know where it came from; it's not, as far as we can see at least, based on what's currently happening in the system. Is 20% roughly the figure of for-profit services currently purchased today?

**Mr Jackson:** Mr Ryan, I'm sorry, there may be a misunderstanding here. The 20% figure is for the pur-

chase of all services, regardless of whether they're not-for-profit or for-profit. In fact, an MSA could say, "We're going to buy zero for-profit services, but only 20% of the total number of services we'll buy will be from not-for-profit agencies." In fact, there's no union protection in this legislation, so they could even go so far as to say, "We're going to hire 20% from outside non-profit agencies who aren't unionized." The MSA has that much power, but the 20% figure—they moved from 10% being just for-profit. They moved that threshold up to 20%, but included everybody.

**1520**

Perhaps that understanding wasn't clear in my question, but that's why moving it back to the 10% actually displaces more workers, because these people can't continue to work for the Red Cross because the Red Cross can't sell that service to people. These workers have to move from the Red Cross and get hired by the MSA. I was always taught that was worker displacement, and so we have to consider their years of service, if they're on an experience grid, if they can transfer some of their benefits package and privileges. All those things are implicit in worker displacement, as you know better than I do.

But I'm just trying to determine in this legislation, there's no protection anywhere in all of this, but moving the 20% down to 10% displaces even more workers than will already be done by this legislation. They will be under this umbrella, but they'll be actually employed directly by this MSA entity. Maybe I wasn't clear enough, but those are the areas of concern I wanted to explore with you.

**Mr Ryan:** Perhaps Margaret could take a shot at that.

**Ms Margaret Evans:** I'll give it a crack. If I understand your question, you're asking whether lowering the threshold from 20% to 10% for purchase of service ends up creating more disruption for those employees who are currently providing services in a number of agencies in the community. I think the whole premise of Bill 173 is based on the idea that we're going to start shifting services from institutions to the community. The whole premise of the new direction for long-term care with multiservice agencies was the idea that instead of having a multiplicity of agencies providing home care services in the community, you would consolidate these services under one agency and provide one-stop shopping for persons in need of long-term care.

So, obviously it's going to result in situations where the employment status of people will change, whereas before members might be employed either by a hospital or a long-term care institution or a public health unit or a municipality or a voluntary agency. Under the provisions of this bill, at least 80% of those persons would be directly employed by the multiservice agency, and what we're saying is that we think that threshold could be 10%.

I think perhaps the key question that you were getting at, and it's an area where I think there's some misunderstanding of what the position of the labour movement is, is that we're not saying that the people in the voluntary sector or people who are not unionized shouldn't go with

the work. We're in support of people who currently perform those services in the community moving with their jobs to the new multiservice agencies.

**Mr Jackson:** Where is that in the legislation to protect that, was my question.

**Ms Evans:** What we're saying is, there is nothing in the legislation and we think there should be and our recommendations 17 and 18 deal with that.

**The Chair:** I regret that our time has run out, but we do want to thank you all for coming before the committee today and for your presentation. I wonder if I could also note, I understand, Miss Evans, that you at one time worked here as a parliamentary intern—

**Ms Evans:** That's correct.

**The Chair:** —and say to members, because we're right in the process now of looking at interns, so people can see that there is life after the parliamentary internship. Welcome back.

**Mr Jim Wilson:** Does she get a chance to comment on it?

**The Chair:** Thank you again.

SERVICE EMPLOYEES INTERNATIONAL UNION

**The Chair:** I call on the representatives from the Service Employees International Union. Welcome to the committee.

**Ms Judi Christou:** My name is Judi Christou. I'm assistant to the president of Local 204. With me are Marcelle Goldenberg, who is the director of research, and Ted Johnston, who is a researcher for the Service Employees International Union. We welcome the opportunity to present our views to the standing committee on social development concerning Bill 173, the Long-Term Care Act.

SEIU represents approximately 45,000 workers across Ontario; 11,000 of these workers work in a long-term care sector and an additional 27,400 workers are employed in hospitals. An estimated 85% of SEIU members are women and a significant number are from minority groups.

This submission has four salient points:

(1) To express conditional support for the intent and direction of Bill 173 to improve the delivery of community-based health care and support services.

(2) To express concern about the lack of definition, detail and criteria in the act; too much is left to undeveloped regulations. Consumers lack choices and can't tell what they will be getting.

(3) To express serious reservations about how the shift to community-based services would impact on SEIU members, especially in light of the lack of any labour adjustment strategy for the long-term care sector.

(4) To express concern that, despite some effort, there are inadequate opportunities for participation by labour, especially at the local level. This lack of input is reflected in the fact that the government's main strategy is to achieve cheaper health care by exploiting workers, volunteers and families.

SEIU is a stakeholder in the long-term care system. The long-term care partnership papers recognized labour

as a stakeholder and promised labour full involvement. SEIU has participated in consultation meetings, focus groups, resource groups, and we previously made a submission to the government regarding Bill 101.

However, despite its extensive participation, SEIU is disappointed that it cannot assume that its message has been heard. It must continue to fight for involvement. Indeed, to read Bill 173, it would appear labour was not a significant part of the process. In making a submission to this committee, SEIU feels it must repeat the reasons why labour has an interest in this reform and a contribution to make.

Naturally, we acknowledge SEIU's primary objective is to protect the interests of its members. At the same time, it recognizes the labour movement has always played a major role in the development and maintenance of an efficient, economical and caring health system. The best interests of SEIU members, more often than not, coincide with those of consumers.

SEIU represents 45,000 front-line health care workers. From another perspective, SEIU represents 45,000 consumers who have intimate knowledge of the health care system and who have always been extremely interested in participating in and improving that system.

SEIU generally supports the five objectives of community service reform as outlined in the act. But at the same time, SEIU is concerned about the number of items and details that have been left to regulations and guidelines. For example, persons requiring care will be assessed by an agency which will determine the type and amount of care they will receive. What this will be based on is not defined.

SEIU is concerned about the lack of choice for consumers as to whether they live in a community or institutional setting. While many people do not want to live in an institution, the alternative can be just as undesirable. The objective of the long-term care reform should be to respond flexibly to the individual consumer's needs. Resources in the system should be able to move where individual needs dictate. The system should respond to people's choices and not unnecessarily limit what choices may be made.

SEIU is concerned with the emphasis placed on the volunteer within the community-based system. Without defining standards of care and proper training expectations, it will be difficult to obtain a reliable level of care for consumers.

SEIU is concerned that this initiative does not live up to the five cornerstones of health care as set out in the Canada Health Act. It is possible for a person to be refused access to community care under Bill 173. The act does not define the basis on which this decision would be made. Whether it would be based on need or on the agency's budget is not clear. Bill 173 also indicates that not all services will be paid for by the government. The compendium states that government guidelines will ensure that consumer fees do not present a barrier to community living. The way to ensure this is to have no consumer fees at all.

SEIU is concerned that the reform will place more

expectations on family care givers and volunteers, most of whom are working women. To expect them to now shoulder the burden of increased levels of care is unjust. If the reformed system is not to exploit women, a range of supports for family members who choose to be care givers must be provided.

#### 1530

Volunteers were always meant to be a complement to the system, not its mainstay. No one knows whether the numbers of volunteers the reform envisages will come forward. Many volunteers are senior citizens themselves. To avoid exploiting them, the reform mandated by Bill 173 should invest in job creation and be less concerned about saving money.

District health councils are and will be required to play a vital and expanded role in the restructuring process. Given the importance of the DHCs' role, SEIU, through the Ontario Federation of Labour, has argued for a total of four labour appointees on each DHC: two as consumers and two as providers. Under the Social Contract Act, the health sector agreement provided that DHCs should include people who bring a labour perspective. Labour has also taken the position that it should have the right to select its own candidates for appointment.

Although SEIU acknowledges that these are volunteer organizations, it has also requested that the Minister of Labour provide the DHCs with sufficient resources to ensure that members be reimbursed expenses and lost wages incurred as a result of DHC duties. If the consumers and providers from the grass roots are to be real participants in the process, this must be done.

Such involvement in the DHCs would fulfil promises of full participation. These same standards of participation should be applied to multiservice agencies.

SEIU supports the safeguards and protection the government has included in Bill 173 for the consumer. However, we strongly believe that consideration for the wellbeing of the workers providing the service is equally important. Indeed, we believe it is critical to the consumer and should be safeguarded and protected in the same way.

At the time of SEIU's submission on Bill 101, we had four units of homemakers in a strike-pending position. Two units of the Canadian Red Cross Society went on strike. It was a long and bitter 14-week strike. These workers earned in a range of \$8.47 to \$9.57 an hour but few if any of these workers ever worked more than 21 hours a week. As one of the workers involved in the strike put it: "For six years, I have been going into the homes of the elderly and disabled in our community and providing housekeeping, laundry and personal care services. During this time, I have not received any of the basic benefits given to other health care workers. At what point do I say, 'enough' and start looking after myself?"

Eleven days after the strike began, the Red Cross announced it was closing its homemaking operations in Dundas and 40 employees were thrown out of work. They never did get their jobs back.

SEIU believes that the local home care program's actions in continuing to refer cases to other service

provider agencies, which in effect scabbed during the strike, are reprehensible and send a clear message to workers that they will be punished if they exercise their right to strike. It also says to the employers of homemakers that they will be discriminated against in the referral of cases because they have unionized homemakers.

The Ontario Labour Relations Board was unable to protect the striking homemakers from being replaced by scabs because of loopholes in Bill 40. However, the board stated in its decision in a case brought before it that it found this result "troubling" since it "emptied any real meaning from the right to strike and hence bargaining rights."

SEIU recognizes that this issue cannot be addressed in Bill 173, but the point must be made: Workers in the community-based sector of the health care system have no protections.

SEIU acknowledges the difficulty of reopening the Labour Relations Act, but as an interim measure, it has recommended to the government that the Red Cross Society and all other employers of homemakers be declared a health institution under the Hospital Labour Disputes Arbitration Act. This would give homemakers the same mechanism that institutional care providers have that ensures that their terms and conditions of work can be settled fairly and equitably by an interest arbitrator.

SEIU believes there is a correlation between quality of care and skilled, trained workers who receive adequate pay and benefits, job security and the knowledge that their employers value their work. This is even more important in community care, where the worker is going into the consumer's home and works independently on a one-to-one basis. But is the issue quality of care or saving money? The compendium is quite straightforward concerning the government's goals when it states that lower-cost workers should be used wherever possible.

Since the beginning of this reform process, the government has been looking into the creation of a new classification: the personal support worker. The intent was to combine classifications already in existence. This would require health care workers who have struggled to attain qualifications, such as the health care aide certificate, to be trained again in order to retain their job or, if displaced within the sector, to apply for a job in the community setting. Is the government going to pay for this or are the health care workers supposed to find the tuition and time on the meagre salaries they already earn?

If lower-cost workers are to be used, does this not mean fewer RNs and RPNs will be used? Just such a scenario took place in St Joseph's Hospital in London when the registered practical nurse and the nursing assistant classifications were declared redundant and are being eliminated in favour of a new classification called the primary care partner. Rather than be laid off, these qualified people chose instead to work and earn \$3 to \$3.50 per hour less, with increased workload and no recognition of health care credentials. In fact, the union submits the job hasn't changed substantially. The RPNs may do a little more housekeeping and dietary work and no charting, but they still do the basic bedside care. The

issue is still in dispute, but morale is at an all-time low and quality of care will not be furthered by this exercise.

Finally, health care unions have been lobbying for a provincial comprehensive, enforceable employment security agreement that would facilitate the redeployment and retraining of workers displaced in the health care sector. SEIU believes that a single province-wide approach is a practical method of dealing with the problem of displaced workers. The health sector training and adjustment program, which is bipartite in nature, would be the ideal mechanism for keeping track of available jobs and available workers. With so much change happening in the health care sector today, a province-wide employment security agreement makes sense.

In conclusion, a glaring omission from Bill 173, which sets it apart from the initial Partnerships papers, is that the government has abandoned any notion that labour should be a part of the process. Indeed, the workers have been abandoned altogether. The health care system is dependent on health care workers. To a great extent, they are part and parcel of the system. They must be given a voice, they must be given decent wages and working conditions and job security. They must be given some respect.

Without assurances to the contrary, SEIU concludes the real objective of Bill 173 is saving money, not maintaining people in their homes.

**Mr Tony Martin (Sault Ste Marie):** Thanks for coming forward today and raising some of the very legitimate concerns that you do. It's certainly interesting to hear you state that in fact unionized workers and workers will be hurt through this exercise. We've been criticized through the piece that this is an effort to unionize the whole delivery of long-term care, so we get it from one side and the other, and I hope you'll understand the confusion that it sometimes causes in us as we grapple with this.

Certainly, it is our intention, through this legislation, to bring the best that's out there re workers to the equation and to have them participate with us in putting in place in Ontario the most comprehensive and professional service we can offer to people in the province who are in need of long-term care.

The question that always comes up re the use of paid workers versus volunteers, that argument that you've heard and we've heard, the concern, is cost. Your allegation here is that this is an exercise in trying to save dollars, when the reality is that we're putting more money into this. We just want to get the best service we can for the money we're putting in. Maybe I could have some comment from you on how you see us achieving that end, while at the same time recognizing that we need to be including as many of your members and members of other union organizations who are already in the field in significant ways in this exercise.

**Ms Marcelle Goldenberg:** I think our first statement is that it can't be in terms of savings, dollars, at any cost. If you're looking at substitution of unionized labour versus the other extreme, which is the volunteers, you're doing it at the detriment of the residents and of the patients. I don't think that's what the objective of the

government is in promoting this particular piece of legislation, or overall in its reform of health care.

1540

If you want to look in terms of cost, maybe we should be looking at the duplication of services that are provided, the administrative costs that are duplicated from one agency to another and the saving that would be realized, perhaps, looking in those particular areas.

In the community services sector, our members are not exactly highly paid members. We're quoting Red Cross workers, who are unionized members, making \$9 an hour on average, whereas the average industrial wage for the rest of the province is something close to \$13 an hour. We're not looking at high-cost employees working in the community-based services at this time. Is that correct? So we shouldn't be looking at the workers who are providing the services to the residents, to the people in the community, as a mechanism to reduce the costs overall in the system.

**Mr Martin:** I'm assuming, in your recommendation that we put in place a plan re the workers who are already in the system, union as well as non-union, that you include in it that we need to concern ourselves about all the workers, not just the unionized sector?

**Ms Goldenberg:** Of course. We happen to be more heavily unionized in the institution sector, at this point, between our hospitals and our nursing homes. It's not heavily unionized right now in the community-based services sector, but any redeployment system in terms of a shift must look at all workers, whether they be unionized or not.

**Mr Martin:** You say here in your brief, "SEIU believes there is a correlation between quality of care and skilled, trained workers who receive adequate pay and benefits, job security and the knowledge that their employers value their work." I certainly couldn't agree with you more. That's something that we as a government, in every sector, certainly believe in and ascribe to.

We just had presenting, before you, the CUPE representatives. When we move into this—I don't think I'm speaking out of school when I say this—we do intend to have a high level of organized labour involved in this exercise. How do we sort out the jurisdictional question of what union represents what workers and that kind of thing? Do you have any thought on that?

**Ms Goldenberg:** I think most of organized labour is members of our affiliates at the Ontario Federation of Labour, and we're very encouraged to hear that there'll be increased union participation and input in the process. I think the least of our problems is going to be in terms of jurisdictional issues, which unions get to comment or be involved. I think the most important thing that we have to recognize, and we haven't seen it in previous submissions or in responses from the government, is that labour has a very important role to play, and it is one of the stakeholders that we need to hear more from. I'm sort of encouraged by that. I'm not so worried that there would be issues and sorting out who gets to be involved.

I think probably channelling most of the information through the OFL, which represents most of the organized

health care unions in this province, would be the same as perhaps going to the Ontario Hospital Association to get feedback from a hospital point of view, because they are the umbrella organization for all the hospitals.

**The Chair:** Thank you all again for coming before the committee and for your presentation.

ONTARIO ASSOCIATION OF NON-PROFIT HOMES  
AND SERVICES FOR SENIORS

**The Chair:** I call on the representatives from the Ontario Association of Non-Profit Homes and Services for Seniors. Welcome to the committee.

**Mr Dan Oettinger:** My name is Dan Oettinger. I'm president of the Ontario Association of Non-Profit Homes and Services for Seniors. My colleagues here are Kevin Mercer, who is president-elect, and Michael Klejman, who is our executive director.

On behalf of the association, I would like to thank you for the opportunity of sharing with you our views and opinions on this piece of legislation, Bill 173, which we believe is very important to the citizens of Ontario. May I also express our appreciation for extending these hearings and allowing other groups, ours in particular, to come and present to you today.

Before we summarize our views, I'd like to make an observation. As an association of service organizations, it's entirely possible that we've been characterized as a rather narrow-focused self-interest group. Should that be the case, there sometimes is a tendency to dismiss what is said as self-serving. However, because we are very convinced that the future of long-term care hinges on the decisions that you folks make here, the advice given to the Legislature, I'd like to urge you, encourage you, to take an unbiased and fair view of what is presented and the information that you gather in these hearings.

We at OANHSS, I submit, are not self-serving and not in the long-term care business for our own benefit. Our volunteer leaders of our member organizations are involved because of their commitment to the health and wellbeing of others. They make no profit for their efforts.

In addition to that, our leaders are grass-roots community people and they have a good knowledge and understanding of what's happening at the community level and are therefore, we believe, in a good position to respond to you on the needs in the long-term care field.

We've waited a long time for an opportunity to discuss and create a new way of delivering services to those who need supports on a long-term care basis. We compliment the government for pushing ahead, in spite of the very negative economic conditions, with this restructuring. However, we have some very serious concerns about how that restructuring is happening.

OANHSS, as a representative of the non-profit facilities sector as well as other care services, has been in the forefront of support and encouragement for the government to reform the system. We advocated for and supported the principles of redirection long before they became a reality.

Today we'd like to share with you our views on what needs to be changed in the proposed Long-Term Care Act to ensure that it stays on track with the principles of

redirection laid out by this government three years ago. I would echo some concerns expressed over here a while ago: I suspect if Mother Teresa were here she would have the same concerns that we do.

We have provided you with documents—I believe you have them now, the full submission—which include specific recommendations for amendments to the bill and a summary of our views and recommendations. In the next few minutes we'd like to highlight those views and recommendations for you, and at the end hopefully we'll have time for some questions, if you wish.

Michael will walk through those concerns for you and Kevin will summarize our position for you.

**Mr Michael Klejman:** Here are some key points I'd like to share with the committee, and also I'll make reference to the amendments that we recommend for the committee's consideration.

We feel that this bill has drifted away from the principles of redirection stated by the government in 1991. Those principles spoke to flexibility, consumer choice, integration, effectiveness and client focus as being central to the process of redirection.

We find in this bill a high degree of inflexibility which has sacrificed the principal point of seniors and others who require long-term care and replaced them as the essential focus with the development of the multiservice agency model, which is rigid and prescriptive in its current description in the act.

Consumer choice has been replaced by what I would like to refer to as a monopoly service that will decide who needs what service and then provide that service.

Instead of the integrating of services that we had hoped for, we see continued separation of health and social services in an artificial way, at the same time wiping out the wealth of services that in some cases took decades to develop in this province.

**1550**

The desired accountability is replaced by an MSA which is beset, we believe, with a basic conflict of interest. When financial resources are limited, which agency will not opt to maximize its revenue at the expense of giving consumers the most appropriate, for them, services? Funds will be directed to a multiyear process of developing MSA-type agencies, forgetting about the principle of cost-effectiveness.

Let us be clear: We do support the principle of restructuring and elimination of the multitude of small one-service agencies through amalgamation of service providers into comprehensive administrative units. But we do not believe that that process should be willy-nilly, should be arbitrary and without consideration of the quality and effectiveness of the existing system.

We also see the loss of client focus in this bill. That is probably the most disturbing to us. The focus in the bill is very clearly on the MSA, the multiservice agency, not on the consumer who is to use the service.

If I may draw your attention to some pages in our full submission which contains our amendments, I'd like to just make a brief reference to the areas that we address in our amendments.

On page 13, we identify the purpose section of the bill and specifically recommend some changes which will broaden the intent of the bill.

Part 2 of our recommendations deals with the segregation of services as contained in the bill, and again we recommend some deletions and substitutions in one of the sections.

We also address, on page 14, the issue of governance, an issue of great concern to our members, and recommend some changes to provisions in the bill which will recognize the role and also allow a fairer process of selecting organizations which will act as coordinating bodies. We also recommend changes under service definitions on that page and then, on page 15, we speak to the financial controls and funding provisions.

**The Chair:** Could I just interrupt, because I think everybody is doing what I am doing, and that is saying, "Where is page 13 and following?"

**Mr Klejman:** Sorry. Building the Framework or Controlling Delivery is the main document.

**The Chair:** We go to page 12.

**Mr Klejman:** So you do not have the complete submission.

**Mr O'Connor:** The Coles Notes version.

**The Chair:** Which is fine as long as we get it.

**Mr Klejman:** I'm sorry, Mr Chairman, our submissions were delivered here on September 13 and there were two documents left here at that time.

**The Chair:** Okay. What may have happened is they're sitting in an office.

**Mr Klejman:** You probably have them in your files but you did not get additional copies today.

**The Chair:** If you want to draw reference to those, that's fine, but I just thought you might be wondering why we were all sort of scurrying around here.

**Mr Klejman:** I will leave the copy that I have with me today, just to ensure that the committee is provided with, to us, the most critical section because that contains the amendments we propose.

I'll stop at this point because I think what's more important is for us to have a chance to answer some questions.

**The Chair:** Perhaps you want to just highlight some of those because, unfortunately, with the number of presenters, we can only have one questioner, and I think you may want to, on the public record, note those and then that also gives us something to use. As we go back and look at your specific recommendations, we can follow that through.

**Mr Klejman:** I'd like to draw your attention to part XII of the bill, which speaks to the powers of the Minister of Health to assume responsibility and control over, in one section, municipally owned and operated homes for the aged and, in another section, charitable homes for the aged.

We believe it's a significant broadening and expansion of powers that were originally contained in the Ministry of Community and Social Services Act and we're asking

that that be reviewed and amended to recognize the legal responsibility and authority, on the one hand, of the governing bodies of those facilities, and not limiting or taking away from the minister the responsibility to ensure the wellbeing of the public that is served through those funds, but also to ensure that there is a more impartial and fairer process to determine under what authority and for what reasons those powers are being exercised.

**Mr Kevin Mercer:** Just a few concluding comments: In our opinion, Bill 173 introduces significant change without truly appreciating the consequences of this change, and in this regard it's worth reflecting for just a moment on the experience we have had in the past 14 months since Bill 101 has come into effect, and I would direct you to page 3 of our submission in that regard. In a nutshell, the promised \$206 million did not materialize and the new regulations on user fees have confused residents and not generated the promised revenue. The highly touted levels-of-care funding system has almost totally been dismantled, and the administrative workload for facilities staff increased while in homes for the aged, staffing and services suffered.

It is our hope that this committee will generate recommendations for amendment to Bill 173 in accordance with the OANHSS submission and the several other submissions that we're aware have been presented to this committee. As Dan mentioned in his opening comments, we are a grassroots, non-profit organization that has a genuine concern for the future of long-term care in this province. In terms of the proposals in Bill 173, those concerns are heightened.

The future, in our opinion, rests in building on current strengths in the system and not a dismantling of the system, and we are certainly prepared to work with the government in that regard.

**Mrs O'Neill:** You're one of the few who have actually talked about Bill 101 in these hearings, but certainly people who I've talked to outside these hearings have compared the two bills, and one certainly doesn't set the most comfortable environment for the other.

I just wanted to verify that you said that Bill 101, in addition to the things that you've suggested—and the one that most concerns me is the mixed messages that are going to residents, and sometimes directly to residents—that administrative work has increased, I think you said, and I certainly have had that verified in other environments, and that the front-line service providers have been able to do less. Did I hear you correctly? Is that due to other things such as expenditure control and the social contract and then Bill 101?

**Mr Mercer:** You're correct. There are a number of factors that have impacted and have presented themselves as pressures on facilities, but we would include in that inventory of pressures Bill 101 as well, that the administrative workload has increased as a direct result of Bill 101.

**Mrs O'Neill:** And service providers in some ways have been cut, either hours or that which they can do? Is that what you said? You gave a second caveat.

**Mr Mercer:** I would not directly say that it is due

solely to Bill 101, but it is a contributing factor, for sure.

**Mr Klejman:** If I could just say one other point, we have also experienced shifts in the funding structure, so besides the question of whether the full \$206 million has materialized or not, there has also been the process of changing the way the funding is working in the facilities sector, and we have experienced losses.

Some of our members have gone through layoffs, reductions in hours, cuts in service, and that was part of Kevin's reference, that while resources are not there to the level promised, and we hope that they will come through eventually, at this point many of our members—and we just attended a meeting, a special session for residents of our facilities today, 300 of them, and staff and volunteers who came with them were all saying to us that they have seen staff reductions, staff loss, deteriorating morale, particularly in those facilities that have been, in the past, touted as examples of quality care.

1600

**Mrs O'Neill:** Okay. Many people who have come before us have suggested that they are guilty of being self-serving. I'm sorry, I don't agree with that, and I certainly am glad you've come.

I wanted to go to a couple of areas. You talked about this bill going to have little to do with quality of life; I think you also used client focus as being lacking. I'd like you to say a little bit about that, in the first part of my question.

The second part of my question: I presume that in some of the facilities you gentlemen are responsible for there are day programs that will somehow hopefully relate to the MSA. Would you say a little bit about both of those things: how you feel quality of life and client focus could have been improved in this bill, and what you see your relationship is to the MSA?

**Mr Oettinger:** If I could respond to the one part of your question and I'll let Kevin respond to the day program question, because he's more involved with that than I am, we see in Bill 173 a great deal of focus on the MSA per se as an agency as opposed to the services required by various groups of people in the community, and a great deal of lack of focus on their needs and their services and rather a focus on what the MSA will do and what it will not do. There was reference a while ago to the 10% or 20%.

**Mrs O'Neill:** Could you give a couple of examples of what you really think has been overlooked?

**Mr Klejman:** Let me just quote one proposed amendment that we put forward, which we feel puts the emphasis or focus on the consumer. In the purpose section of the bill, we recommend that an addition be made that reads:

"The purposes of this act are,

"(a) to recognize the person's needs as the most important factor in managing and delivering community services, and individual preferences as another major factor."

That kind of emphasis or strength is not there in the bill right now.

**Mr Oettinger:** To simply set a finite level of services that must be provided by the agency, the MSA per se, and may not be purchased outside is to focus on the MSA as an organization rather than the client. Rather, we need to find out what the client needs and get that service, wherever it may be, by whomever it may be rendered, to meet the client's needs, not setting a limit on who will do it or who will not be permitted to do it.

**Mr Mercer:** We would suggest as well that one of the major difficulties in the long-term care system has been awareness of access and how people obtain information around services that are available. We believe that in terms of reforming the system, that problem has been overstated in terms of the general system and that the MSA is looking at the creation of structures that centralize as opposed to building on the strengths of the community delivery system that has been developed over an evolution of years and is based on good, solid community values.

**Mrs O'Neill:** You were going to say something about your day programs.

**Mr Mercer:** In terms of day programs, it would be our opinion that they should not be included as part of the MSA, that there's no reason why they could not be kept outside of the multiservice agency. They operate as a continuum of care quite often with facilities and there's no reason why they can't function and operate quite well in that regard. I guess we would present that argument for a number of the community agencies, that there really is no rationale, no documentation that we have seen, that would indicate the benefits of the centralization that is proposed.

**Mrs O'Neill:** In the first week of the hearings we had some discussion about this. I think it was in Hamilton. Has there been any more decision-making around that area regarding community or facilities with day programs and their relationship to the MSA by the government?

**Mr Wessinger:** There certainly have been no further decisions made with respect to that matter at this stage.

**Mrs O'Neill:** So there's no consideration of exemptions for existing day programs.

**Mr Wessinger:** Well, there is consideration. There are a lot of items under consideration. I just wanted to indicate that no decisions have been made. There's the different matter of what one is considering and what one is deciding to recommend.

**Mrs Sullivan:** That's a pretty fair commitment to eliminating the day care programs that were provided by facilities from the 80-20 formula.

**The Chair:** Mr Klejman, did you wish to comment?

**Mr Klejman:** Yes, I do, and maybe I'd like to come at it from a slightly different perspective. What's unique to our sector, the non-profit sector, has been a strong philosophy and practical efforts to develop what we call continuum-of-care models. These are environments where seniors live when they are totally independent, in independent housing settings, and if their needs change, there are other resources available to them, day programs being one such resource.

One of our concerns, and I know it wasn't the intent of

Bill 173, but the impact of this will be fragmentation, in some cases dismantling of these continuum-of-care concepts, where to access one service or another service will be a decision of an MSA, not of the organization or the person who is living in that community and using those services.

**Mrs O'Neill:** Several have brought that to our attention.

**Mr Jim Wilson:** Mr Chairman, If I can just say, this is one of the most comprehensive briefs I've seen, and I hope the government takes note of page 8, where it lists the litany of costs you've imposed during your term on these homes. I'm surprised there's any money left in the system to actually look after residents. I hope you take a darn good look at their analysis of Bill 101 and the litany of new costs you've imposed on this system, because this is one of the best comprehensive set of Coles Notes I've seen, and you'd better bloody well take a look at it.

*Interjections.*

**The Chair:** Order, please. Gentlemen, thank you for coming before the committee. I should note for committee members I believe, Mr Oettinger, tonight you step down as president and Mr Mercer becomes the president. I was going to inform the members. I don't know whether that means you turn into a pumpkin or just what happens.

**Mr Oettinger:** I'll be around for a little while longer.

**The Chair:** I'm sure you will and we wish you well, and also Mr Mercer in your new functions as president. Thank you again for coming.

#### AD HOC CONSUMER COALITION ON LONG-TERM CARE

**The Chair:** I invite the representatives from the Ad Hoc Consumer Coalition on Long-Term Care to come forward.

**Ms Patti Bregman:** You're just going to have me. You're stuck with me.

**The Chair:** That's quite all right. I was sort of expecting a larger group, but you're more than welcome.

**Ms Bregman:** My name is Patti Bregman. I'm a lawyer at the Advocacy Resource Centre for the Handicapped, and I'm here alone. My colleagues apologize; they've been tied up at other meetings, which are ongoing, about long-term care.

We decided in August that the consumers needed to be heard from more effectively, because basically, and we've been following Hansards, there has not been a strong consumer voice before this committee, and we brought together a group. The list of the groups that formally signed on is attached, and there are a number of other groups around the province that I've spoken to since. I just got back from London this morning. We wanted to show that you can bring together consumers who represent people with AIDS and seniors and people with physical disabilities and people like myself who've got invisible disabilities. I've been on the home care system for eight years now. I consider myself extremely fortunate to have benefited from the system and cut my hospital days from six months to less than 30 in a year, and I think that's quite remarkable. We wanted to address

the key issues, as we see them, from the perspective of the consumer.

We will not be addressing the issue of the multiservice agency. There are a number of complexities in that.

To be honest, from our perspective, there's not a whole lot of choice in the system right now. Despite what we hear from service providers, in the eight years I've been on long-term care, I have never had an option about where I get my services and who I get them from, and sitting as a lawyer who deals with a lot of people who come in to complain about the system, I also know there are an awful lot of people in this province who not only don't have choices but have services cut arbitrarily, decisions made for them that are inappropriate. So we're presenting in that context.

I think what we've looked at as the focal points are the consumer protection and strong bill of rights, the complaints process, quality assurance, the regulation-making process and the accountability of the district health council, which, as I've travelled in the last month, is giving me increasing cause for concern. There is a great deal of disparity in terms of how they act. I will not go through all of this. I'll try and highlight those areas in particular where we are making specific recommendations.

We think the bill of rights is essential and are extremely pleased that the government listened to us on the bill of rights and made it something that is actually enforceable. We've seen what's happened with the nursing home bill of rights, where it's very difficult to enforce. This will finally give people some power to go out without having to rely on the government to intervene or without having to rely on a service provider to suddenly decide, "Yes, we'll agree." In all of the system, we've got labour, which has had a very strong voice, we've got service providers, who have a strong voice, and the government, all of whom have contracts with each other, and the consumer isn't party to any of them. We think this bill of rights will start to address that disparity in the power relationship.

We're really pleased that it covers all service providers, not just multiservice agencies. There will still be services provided by other agencies and there should be no difference in the kinds of rights that are provided.

**1610**

We're also extremely happy about the provisions preventing harassment for people who complain. We dealt with a situation in Windsor, which I think all of you are aware of, where clients who complained were forced into hospitals, were evicted, were threatened with withdrawal of services, to the point where the ministry had to take it over in April, and for that we were extremely grateful. That shouldn't have to happen. This will hopefully give them some protection.

Finally, we'd like to add a couple of things to the bill of rights. One deals with information. We're glad that throughout the act it talks about having to provide information. That's been a major problem for a lot of our clients, that they just can't find out what the rules are that govern the providers. But what we would like to see

added specifically is that the information be provided in accessible formats, in Braille, on disc, on tape, and in plain language, because handing somebody who's blind a piece of paper they can't understand is not providing them with information, and unfortunately it's our experience that unless we specifically say it must be accessible, we won't get it. For example, I can't get this piece of legislation in an alternative format, which means there are all kinds of people around the province who cannot participate. That's an extremely serious concern from our perspective and needs to be addressed in this legislation.

The other area where we have some concerns deals with abuse. We are getting an increasing number of calls from clients who are forced to receive intimate services from attendants or service providers of the opposite sex. This can't continue. For obvious reasons, people with disabilities are extraordinarily vulnerable. In some cases, they can't speak. We've had a number of cases recently where even after a client was raped by a provider, they were still forced to have a male provider. Unions have taken the position that they can't be forced to go to only one gender; it's taking away their experience.

That's not acceptable, and we would like it added to the bill of rights that there is a specific provision that says you may choose the gender of your provider where it's intimate care. Obviously, if it's a homemaker, there are situations where you don't need the choice, but where somebody is vulnerable, you're going to the house, you can't speak, we need to have that.

Consistent with that, we would like an exemption from the 20% brokerage restriction. An MSA may not be able to provide the same-sex provider, and we need to make sure they can't say, "Oh, well, the 80% rule holds us in." We'd like that to be made an exception, that where either there has been abuse or where you need to have somebody chosen of the same sex, that is exempt from that restriction.

In terms of enforcement, it may sound strange coming from a legal clinic, but we would like to see some middle ground in terms of ways to enforce both the bill of rights and complaints process. We don't think lawyers are the appropriate people to intervene in every case, and in fact I think in a lot of cases lawyers are probably not the best people. The Advocacy Commission will be able to help to some extent, but we would like to see the government consider putting in some provisions for alternative dispute resolution, mediation and provide for the funding, because right now we do have mediation going on, but it's usually with volunteer mediators, and I think that's unfortunate, because it will save a great deal of money. We don't think you need to start in an adversarial position. You may end up there, but that is not how we want to see it.

On the other hand, where there are serious breaches of the bill of rights, we also don't want people to always have to go to court and would like the legislation amended to specifically provide that where there has been a serious violation of the bill of rights, that is a specified grounds for potential revocation of an approval or a designation of an MSA. If we're seeing consistent violations, it shouldn't mean that every single one of

those clients has to go to court before the ministry takes a look and says, "No, that's contrary to the act." You need to be able to step in.

We also would like service providers to receive some education and provide education for their staff on sexual abuse, and we think this is extraordinarily important. The government has recognized this within the context of the regulated health professions. A lot of the providers in the system will not be governed by that, and we do think it's an obligation of the government to both require it but also to provide subsidies to those providers who are going to have to add on another piece.

In terms of quality assurance—I'll skip over to that on page 9—again we're pleased that there's a provision, but it's extremely vague. I guess what we don't want to see happen is a bureaucratic quality assurance program of TQM or CQI or whatever the language is. The AIDS community has been extraordinarily effective in working with consumer-driven partnerships with providers to develop the standards that are going to be used to measure, to be participating in the evaluation, and I think what we would like to see here is some specific provision, whether it's in the regulations or the legislation, that says that quality assurance (a) will be independent and (b) will involve the consumers of the service along with the providers at every stage in setting standards and evaluation and in discussing what it is you do with the information at the end.

We don't see quality assurance necessarily as having to be punitive, but something has to come out of it. It should not be something we just do for show. Information has to be available. We need to use it to find where there are problems in the system.

I was speaking last night to the London Cheshire Homes Foundation at their annual meeting. They're starting a new quality assurance process that involves all of them, and they see it as a dynamic process. "This is how we'll see what will happen with our services in the future." I've given you an article that kind of puts together some of that perspective, which I thought you might be interested in, just for your own time.

Finally, two other areas: One is the regulation-making process. I think you've heard before there are concerns that so much of this legislation is left to regulation. I can understand the need for flexibility, but I'm very concerned about the lack of accountability, so what we're recommending is that, number one, there be put into place a permanent form of an advisory council that would have joint representation that would have the mandate for reviewing all regulations and that, like the Regulated Health Professions Act, there be mandatory public consultation on the regulations so that we don't wake up one morning and find out that we've got user fees, or we don't wake up one morning and find that eligibility criteria have suddenly changed. We need to have it in the legislation.

There has got to be some kind of public accountability and public process so that we're aware and we all know who to go to and talk to. Right now there are a number of internal government committees. I can't tell you who's on them. I've asked, and I'm sure I'll get an answer, but

we need to somehow formalize that process so that the community can connect, service providers can connect and there's some more certainty in the system and we're not all running all over the place. There's a lack of coordination right now that I think needs to be addressed.

Finally, in the area of governance, we're pleased about consumer representation but somewhat disturbed that there's no definition and no specific requirements. What we're proposing is a definition that would basically say it's people who are currently using the services or within a short period of time of using the services. There is a very different perspective. While all of us may at some point be consumers, I can tell you from my own experience, it's quite different. I know what it's like to wake up in the morning and the nurse doesn't come, or if I get cut off the program or if they change it.

I think you need that perspective there, in part to keep it practical. I think a lot of people who use services are very good at telling you how to save money on services. I think they see the overbureaucracy, they see the administrative costs, and they need to be part of that. So what we're recommending is that you don't have consumers who are also service providers. We think it's a conflict of interest. We know of district health councils that have appointed retired doctors as "consumers," and we think this needs to be addressed.

We also think there needs to be a mandate in there requiring accommodation. We have people who can't get to meetings. It's great to have consumers, but if you have meetings at times people can't get to, if there's no transportation, if they don't have the time and the expertise to read the material and prepare—and you have to recognize, these are people who do not do this for a living. I do it for a living, so I read the thousands of pieces of paper that come over my desk.

What we need is to find a way in which people can truly participate. We don't need a lot of committees, we don't need hundreds of meetings, we're not suggesting that we want to spend all our time in meetings, but we need the district health council to have a mandate.

The Metro DHC, for example, does not have a telephone device for the deaf, despite it being raised with them, and that's just not acceptable. I've found as I've travelled the province that there are accessibility problems. Information's not provided in accessible formats.

So I think that's going to have to be in the legislation, or at least in regulation, that one of the requirements of the district health council is one third consumer representation, using a definition that is truly a consumer, but also a positive obligation. Right now they're getting a lot of money for consultants. We think some of that money has got to go back to the community.

**The Chair:** Thank you very much, and I'd just underline that your brief goes into far more detail than you have been able to, and also the article you have appended to it on the quality-of-care paradigm.

1620

**Mr Jim Wilson:** Thank you, Ms Bregman, for your presentation. I think you've got a very good brief here, and it's very comprehensive. I particularly appreciate

your latter comments about district health councils. The title of the point is "The accountability of the district health council," and I know you're trying to improve accountability by improving consumer participation and representation on district health councils, but I'll tell you, I travel the province. I'm not sure that's going to cure things—

**Ms Bregman:** Oh, I agree with you.

**Mr Jim Wilson:** —just adding more consumers, because it seems to me our district health councils are getting into a group-think mentality, no matter who gets appointed to them, and I'm quite fed up with some of them in terms of their being perceived as fronts for government policy now, rather than what they were originally designed for, which was to be the ears and eyes and spokespersons and advocates for the communities that they're there to represent. They're not to be front shops for government policy, which is what I'm running into in a number of parts of the province.

Just so you'll know, I want you to comment on that, because I'm not sure just adding more consumers is going to improve what I think has been—and I don't blame the people, and the good people, who volunteer for district health councils; I blame the government and the way they've been used—the way they've been used in the Legislature—as political crutches and fronts for government policies. Can you just comment on that?

**Ms Bregman:** It's a hard one to comment on. I don't think just putting consumers improves accountability. I think there are things like open meetings and ways of dealing with it. In essence, regardless of whether they're speaking for government policy, devolving something off assumes they are going to be making the policy decisions at some point, and I think there is going to be this tension. At the moment I'm not quite sure what the answer is. One of the things we're about to embark on is in fact developing a consumer network to monitor what's happening at the district health councils.

**Mr Jim Wilson:** Well, that's a good idea, because I just got off the phone with central Ontario district health council people who are doing a dialysis study and I'm told everything's secret.

**Ms Bregman:** Yes. Exactly.

**Mr Jim Wilson:** What the hell are things secret for in a district health council?

**Ms Bregman:** Well, in fact, in the MSA proposals, in one district health council consumers are not allowed in the door. That's a very serious concern. I can understand they don't want "constituencies," but when they tell consumers, "You're here just for yourself; you don't tie to anybody," we think that's a problem. It's not that we expect all of them to take the same position, but our approach is, we did this brief with no money. We're probably the only group in this entire process that has absolutely zero dollars to do this.

**Mr Jim Wilson:** Congratulations.

**Ms Bregman:** Well, it's good, but it also is a problem. But what we're struggling with is, how can we effectively communicate with those consumers so that they understand the issues at the grass-roots level,

because I think the way to make the district health councils accountable is to make the members accountable. It's not going to be something the government can do or say. I think we have to go to the members and say: "We're holding you accountable. You're there." I think that's the way things are going to devolve and change. So I think it's going to have to come from us, and we're just looking for mechanisms that will allow us to do that right now.

**Mr Jim Wilson:** I really appreciate your comments along that line. I have one more quick question, and that is with respect to the bill of rights, because you did give us some comment on that, and extensive comment. As written, it's a deemed contract. Can you give me in layman's terms, if the bill were to go through now, is there any other mechanism in there other than resorting to the courts? There's the appeal process along the way, I suppose, but are there enough teeth in there now if the bill were to be passed as drafted?

**Ms Bregman:** I'm not sure you could put much more in, to be honest. I think, if we have the question of whether or not their approval is subject in part to this, which I do think needs to be added specifically, and if we can develop some kind of complaints process that really works, that's independent, and I think we've recommended that there need to be stages of that, then I'm hoping that that, combined with advocacy, will enable the people to feel more comfortable.

A lot of providers are fine. Many of them are good. But the ones who aren't—and we now have a number of quite serious complaints—I'm hoping at least if they see that people have rights, people will now become more empowered to work with tenant groups, for example, or form their own little groups to try and sit down with those in power, sit down with the government and work it through. What happens now is, consumers will not get together and organize, because if they do, they're harassed. So what we see is this freeing some of that up.

I'm not sure you can put it in legislation without it becoming very cumbersome. I think it will be a very flexible process, but I think the more we make these organizations accountable and the providers accountable and they know people have rights, part of what our job is now is to educate the consumers about what those rights are and give them some suggestions. I think a lot of the organizations in the disability community are starting to work on that, to help people develop things, and work with service providers and get them to change and develop processes that are accountable.

**The Chair:** Thank you very much again for coming. While we're sorry that your colleagues weren't able to be here with you, you have represented their views very well, so we thank you.

#### ONTARIO ASSOCIATION FOR COMMUNITY LIVING

**The Chair:** I'd like to then call on the representatives from the Ontario Association for Community Living. Welcome to the committee.

**Ms Cheryl Easton:** My name is Cheryl Easton, and I'm the president of the Ontario Association for Community Living. I would like to introduce Jim Mahaffy,

who is our first vice-president, and Barbara Thornber, who is our executive director. I will be sharing this presentation with Jim, who is the chair of the promoting community living options task force. This has been something that has been very central to us for over 20 years of our 41-year history as an advocacy group.

Today our grass-roots membership is over 15,000 and we are a federation of 115 locals whose budgets are anywhere from \$500 to over \$40 million, so you know we're just slightly diverse. We work on behalf of and work with people who have intellectual disabilities or who are labelled that way. We're also very much in concert a lot of the time with People First of Ontario. We join sometimes in coalitions and other times we're fighting, but that's okay. We respect one another's opinion and who we are.

Since the early 1970s we have successfully integrated or brought back from institutions 6,000 people, some of whom were deemed very hard to support, and we have done it. We were not good at the beginning; we're better now. There are still another 2,000 people remaining in institutions of the estimated 30,000 people that we support.

Today, spending on developmental services in Ontario is just under \$895 million.

Despite our successes, there are fundamental problems with our present system of delivering community services for people with developmental handicaps. The system within the community is in itself a form of segregation. We tend to have people phone and say, "You're the experts." Well, we're not the experts on people, because people are very diverse. As you and I live in a community and want our rights respected and want to be a productive part of the community, that's all we're asking for people we're advocating on behalf of.

What we do with group homes and other things is an institutional practice in itself. We're developing programs and then putting people in them according to their label or "functioning level" or a whole bunch of other really ugly terms that I don't ever want to be associated with myself.

Now I'll talk a little bit about our interest in long-term care reform. We understand that people with developmental disabilities have not been included in the current reforms, which is very upsetting. We have prepared these comments that Jim will give you on the future reforms to the system of delivering community services to people with developmental disabilities.

We are seeking a fundamental shift in thinking about how services are developed and delivered. We're asking you to look at people, regardless of who they are and where they come from. The reforms proposed in Bill 173 are but a reorganization of the existing system of delivering services, and that's really scary. Our position is that we need to move away from an organization-based system to one which is individual-based and measured in terms of the people outcomes. We want people to be able to have lives, not programs.

I once asked someone the difference between life and a program, and this person said to me, "A program is

limiting; life is limitless." Sometimes our programs really do cause people to have real limitations. So we are asking for a shift from specialized, segregated services to support systems in the community which recognize people and their uniqueness, because we all contribute in different ways. All of us sitting around this room contribute.

### 1630

People with developmental disabilities should have access to all services in the community, whether it be the hospital or the library, and community services should be based on individual needs so that the supports are built around the person as opposed to a program that a person fits into. Because there's a spot in a program doesn't mean the person should fit it. So why do we take a peg and try to—I don't know how you say that, but you try to ram it in something that it doesn't fit.

**Mr Jackson:** A square peg in a round hole.

**Ms Easton:** Well, thank you, Mr Jackson. I appreciate that. I would expect that from someone from Burlington.

### *Interjections.*

**Ms Easton:** Well, I'm from Burlington. I grew up there. That's okay.

**Mr Jim Wilson:** His children have block sets.

**Ms Easton:** Oh, is that what it is? He's learned, has he? What can I say? I will now turn it over to Jim Mahaffy. Go for it, Jim.

**Mr Jim Mahaffy:** Thank you, Cheryl, and good afternoon. What I want to do is get right into the specifics of Bill 173 and try to underline a few of the points that underline what Cheryl was talking about in terms of a fundamental shift in terms of supporting individuals and not looking at programs as being the be all and end all.

To begin with, to address the legislation's proposed bill of rights, OACL supports the important, very new protections provided in the bill of rights for persons who receive services. The need for such a bill was outlined by Ernie Lightman in the report of the Commission of Inquiry into Unregulated Residential Accommodation, but unfortunately Bill 173 is silent on enforcement mechanisms other than litigation. For the people we represent and others, we feel the forthcoming regulations must provide for an easily recognized and accessible process for people to enforce this bill of rights.

I would like to next discuss our position on individualization. OACL generally supports the principles which have guided long-term care reforms. However, the association finds that Bill 173 is not sufficiently strong in recognizing the importance and the primacy of the individual. Specifically, OACL wishes to see part I, clause 1(c) include the principle of individualization, which "Asserts the basic human right of the person to have his or her unique capacities, interests and needs recognized and used as a basis for planning, developing and delivering such supports"—as we're considering here in long-term care as well as others—"as are required by an individual to live, learn, love, work and spend personal time."

In keeping with the principle of individualization and consistent with it, OACL advocates individual, consumer-directed funding, defined as: "A system in which funds

for services are individualized (tied to the person).... The individual either manages the funds and engages support staff himself, or hires a manager to perform this function." OACL would like to see Bill 173 specifically provide for individual, consumer-directed funding.

Moving on to multiservice agencies, OACL feels that the government must address the issue of individualization, including consumer-directed funding, before proceeding with the development of the multiservice agencies. We feel very strongly that the government must establish principles and a process for reforming services to address individual needs before looking at mechanisms for pulling the various services together, looking at essentially what the needs of the services themselves are before tackling what we feel are the principles involved in addressing individual needs.

Having said that, we do support the establishment of coordinated access to a full range of long-term care services, but we do not support a service system which provides for only one choice of service provider.

Finally, on the subject of governance, if the government persists in developing the MSA model as currently outlined, OACL is concerned that the proposed legislation is not more specific with respect to the composition of the boards of district health councils and the proposed multiservice agencies. We feel that the act should set out a majority of consumer representatives on these boards. Furthermore, supports should be provided to ensure that consumers are effective representatives and not merely tokens in this process.

In fact, the Ontario Association for Community Living is concerned that the Ministry of Health, having the lead role through the district health councils in planning long-term care services, could impose or will impose its historical medical model on the newly developing system. OACL views the medical model as top-down, centralized and professionally driven.

Historically, we feel social service organizations have had stronger community representation than their medical counterparts and have made much greater uses of the resources of the community. This is in keeping with our philosophy in community living. We feel that the natural supports of the community must be considered in overall planning around individuals as well as paid services and supports.

In conclusion, long-term care, if it is to live up to its stated objectives, we feel must be collaboratively planned and implemented by all those affected by its outcomes.

**Ms Carter:** Thank you for your presentation. Certainly I have a great deal of sympathy for the point of view that you're coming from. I think that it is the consumers and the individuals concerned that have to be the focus of what we're doing, and I believe to a great extent that is happening, and I am certainly interested to hear from you the ways in which you feel we are meeting that ideal, if you like.

Interestingly enough, we had a presentation yesterday from Dr Michael Rachlis and Carol Kushner, who have written books on this sort of topic that you might know about. They reminded us of a system that exists in

California called On Lok, where the money does in fact go with the individual rather than with the system.

I think a lot of us feel that this is a kind of goal that we should be approximating to, where the emphasis is on helping people to function rather than medicalizing them, as you have said. They did see what we're doing in Bill 173 as something that was at least beginning this process and which could evolve in that direction. They didn't see it as something that was cutting off those options. It may be that rather than reaching the ideal tomorrow, we do have to evolve, go through a process of getting existing agencies to come together and taking it on from there.

I certainly agree with you about consumer representation, genuine consumer representation, with power on boards as being essential. As you know, we do at least lay down in the act that 30% shall be such. So I'm just wondering whether you don't see flexibility in the system as it is being suggested and the possibility of evolving to the kind of thing that you want.

**Mr Mahaffy:** One of the main concerns we have that I mentioned perhaps very briefly is that it seems the government's intention is to designate the MSAs as being sole service providers. One of our central concepts in terms of individual planning is somewhat of a brokerage model, where people are able to go and access the supports they need in the community among people who may have varying types of abilities to be able to respond; for instance, a neighbour or someone like that who's able to provide support on a daily basis or a community agency where, say, a senior would want to contact someone who works for a community living association, or that kind of crossover. We don't see that this kind of flexibility is built into the legislation the way it is currently.

**Ms Carter:** I certainly agree with you that we want to have those possibilities of using what maybe is common sense as to what the ideal arrangement for a particular person might be, and I believe that's happened in other countries, that you maybe pay the neighbour to support a person or whatever.

But the way I see it, by bringing agencies together and centralizing the assessment of the person and the decision-making as to what they need, I think we're bringing in a lot more flexibility than we've got at the moment, where we have very discrete agencies with very definite mandates. Hopefully, when they're closer together there will be all kinds of permutations of service that will become possible.

1640

We heard some time ago from Victoria County Community Care. They're not technically an MSA, but they are an amalgamation of existing agencies that has a lot of similarities with the multiservice agencies, and they certainly did feel that this gave them the possibility of being very flexible and being able to adapt to the needs of individuals because, as I say, we have a sort of pooling of all the possibilities, and because of that pooling it's much more possible to sort of pick and choose for an individual from the possibilities that are available. Of course, an individual's wishes are a very important part of what will finally be put together.

**Mr Mahaffy:** If I can comment, we certainly do support a single point of access into the service system, and we see that this is something that could dovetail very nicely with our approach of individual, person-centred planning. What we see is that person-centred planning is a very holistic approach, that someone's wellbeing and their level of functioning in the community is often built not just on the kinds of services that we might identify as long-term care services and that an approach that considered the holistic wellbeing of the individual could include access to a range of long-term care services but might also include other factors which would contribute to someone's wellbeing which weren't necessarily considered to be part of that package but might be very easily realizable through that person-centred planning process.

**Ms Carter:** I think that the local base of the MSAs, rather than having a bureaucratic structure, should make them more able to be flexible and to involve other parts of the community, if you like, in tailoring the services to an individual. I'm sure that is what we have in mind. I don't think there's any disagreement with you at all that that's what we should be doing ultimately. So I just hope that we can approximate that as fast as possible.

**The Chair:** Thank you. Any last thought or comment?

**Ms Easton:** I would just like to comment on that. I think there has been a lot of informal sharing of information and also trying not to categorize people by, "You're this" or, "You're that" or, "You carry this label" or, "You carry that label." I think that when you talk about your multiservice agencies it doesn't include churches or Lions clubs or any of those sort of things that provide a lot of informal support. I think if we get into really hard-core stuff, we're going to miss the boat on a lot of things that are done by a community that are just good things, just because they live next door or they're a part of the community and they belong to the Knights of Columbus or whatever it is. So I'd worry about that a little bit with the one-stop shopping, because whenever you one-stop shop, a lot of times when you get into multiservice agencies, they trade you about.

**Ms Carter:** As I said, they will all be locally based, and hopefully they will have links with the Lions Club and all those other things and they'll be able to use their help.

**Ms Easton:** Well, I hope so.

**The Chair:** Thank you. I'm afraid we're going to have to close it there, but I think many of us around this table know of the excellent work of the OACL, and it's good to see you all again.

**Ms Easton:** You always will see us, fortunately or unfortunately.

**The Chair:** I know that, Cheryl.

**Ms Easton:** Did you allow Jim to say his last thing?

**The Chair:** Oh, sorry.

**Mr Mahaffy:** I just wanted to say that, like the previous presenters, we would also like to see some input into consultation around the regulations for Bill 120 as well.

# LEARNING DISABILITIES ASSOCIATION OF ONTARIO

**The Chair:** I call the representatives from the Learning Disabilities Association of Ontario. We want to welcome you to the committee. I have to say, Eva, to you that you have gone from one position to another, but it's got a lot more words next to it. I don't know whether that makes you more powerful and authoritative.

**Ms Eva Nichols:** Not at all.

**The Chair:** Just the same warm person. Okay.

**Ms Nichols:** I'm just a consultant today.

**The Chair:** Well, we want to thank you for coming to the committee today. If you introduce yourselves, we have a copy of your presentation and please go ahead.

**Ms Nichols:** My name is Eva Nichols, and I am now called a consultant in advocacy legislation and government liaison, which is indeed a lot more words, but it also spells out very clearly what my revised role is with the Learning Disabilities Association.

Immediately to my left is Sharon Bell-Wilson, now the executive director of the Learning Disabilities Association, and next to her is Tanya Lewis, assistant executive director and program director.

We are going to start out with me making some introductory comments, not very long because you have our written material in front of you, and then hopefully you will have some questions for us which we will all three respond to as it seems appropriate.

First of all, we would like to thank the committee for arranging these additional days for the consultation. I'm sure you've found that there has been a lot of interest in the issue of long-term care, perhaps more than you had originally anticipated, and I think that may be in part because the mandate of what came under long-term care seems to have expanded significantly since when it was first announced in 1991 and people were talking about services to seniors and to people with physical disabilities. That is at least what the minister announced at that time. The additional things that seem to have come in under the multiservice agency model I think have meant that a lot more people have become a lot more interested, and a lot more concerned in some cases.

I would imagine that many of the people who have come in front of you have talked about the details and the minutiae of what is included in the bill. As is so often the case for people who represent people with learning disabilities, our fundamental first comment to you always is that we are still concerned about equity issues and the whole question of people with learning disabilities being included.

If we were engaging in a one-to-one dialogue, you may say to me, "Well, where is there in Bill 173 that people with learning disabilities are not included?" and I would certainly agree that that is not so. Nevertheless, all the discussion, all the dialogue that has gone on with some of the staff of the Ministry of Health, for example, has indicated that the school health support services, speech and language pathology services, social work services that will be included in the mandate of these multiservice agencies will not include services to people with learning

disabilities. So our first and most important concern to place in front of you is, please would you ensure that the kind of discrimination that people with learning disabilities face doesn't continue in their being excluded once again in this area.

I think the other point we would like to put in front of you is that we have some concerns about the whole business of communication as to how all of this is going to develop. It seems to me that involving people like school boards and the organizations that are particularly concerned about school health support services has not appeared to have occurred as effectively as it might.

For example, the Ministry of Health was going to circulate to all school boards and all agencies concerned with school health support services a revised manual for the delivery of school health support services in time so that you, as a committee looking at this bill, could look at what all those organizations really believe about that. I know for a fact, because I checked yesterday, that those manuals have not yet been sent out for consultation to the school boards and to the other organizations that are to provide input. It would be a tremendous problem, I think, for this province and for the people this bill is supposed to protect from all kinds of terrible things if in fact that consultation occurred after you had done your clause-by-clause review, there had been third reading and somebody would say, "Excuse me, but have you considered all these various things?"

I obviously don't know who has been in front of you, maybe you have seen all 180 school boards here commenting on that particular issue, but I think it's an example of the lack of communication that appears to be out there. While people fundamentally support the deinstitutionalization thrusts of this bill and its one-stop shopping thrust, we want to be very, very sure that when it is finally proclaimed, whenever that occurs, it truly reflects the needs of all those people who need to use long-term care services and in particular that it includes people with learning disabilities who need those services.

1650

**Mrs Sullivan:** I appreciate this brief very much because I am deeply concerned about the integration of children's services into the multiservice agency. I think that there has been little planning and that the original concept in fact did not include children. The thinking was that children's services would be dealt with in another manner, and perhaps that's the most appropriate way to go. In fact, that's certainly my leaning.

I raised yesterday in committee the question of children and how they will be included in the bill, and unfortunately we have not had time for a full briefing for the committee from the ministry with respect to the intentions about children, but it seems to me that when home care is now mandated to provide school-based health support services, when home care also provides much of the service that's provided in-home or in the community base and establishes contracts with treatment centres and so on, given that home care is going to be integrated into MSAs, there is no option other than that children's services are going to be included here.

I look at the list of required services, the mandated

services, and I think having mandated services across the province so that there is a basic basket is appropriate. But why, for instance, are only adult day programs included when day programs for children, particularly at the preschool age, may well be an important part of the service delivery?

I did not know what you have pointed out in your brief, that in Metro, and I'm just quoting from the brief, "...it has been stated that while school-based health support services are a part of the process in principle, services for children will not be included in their proposed multiservice agency plan until the review of services offered through the Hugh Macmillan and Bloorview centres for children with physical disabilities is complete."

You go on to speak about speech and language pathology. I'm concerned that, for instance, while speech and language pathology is included as a mandatory service under professional services, for the elderly, frequently the work that's done by the speech and language pathologist relates to swallowing and is a very different kind of service from what is provided by the paediatric speech and language pathologist.

I'm going to ask if the ministry and the parliamentary assistant can respond at least briefly now on the intention of the minister with respect to children, if it's the intention that children's services would be included in a regional MSA that would—the Metro situation is going to be extraordinarily difficult with 17 MSAs, or 22 or however many they end up with, none of them with a particular emphasis on children, whether those specialized services would be included or whether the ministry has considered limiting this bill, as it limited Bill 101, to seniors and people over the age of 16 with disabilities.

**Mr Wessenger:** I somewhat anticipated that would be your question, Ms Sullivan, so I'm going to ask Mr Quirt to respond. I think we should be clear that children are part of the MSA structure, but how they're going to deal with it I'll ask Mr Quirt to indicate.

**Mr Quirt:** First of all, they've always been a part of the long-term care client group and a part of the long-term care redirection, going back to the mid-1980s. Ever since the home care program has been involved in providing services to children, whether in school or at home, they've been an important client group that needs to be served. There was never at any time a contemplation that they wouldn't be subject to the improvements in the long-term care system, and as a result there is no intention whatsoever to reduce the amount of support provided the children at home or in school through the school health support services program.

With respect to children's treatment centres, which has been raised yesterday as an issue and again today, children's treatment centres will continue to be funded from three places: They get funding from the Ministry of Education and Training now for some of the services they provide. They get core funding from my division for another group of services they provide. Third, when home care programs or the MSAs are going about fulfilling their mandate to deliver the school health support services program, they need to arrange for the provision largely of

therapies to kids in school, whether it's PT or OT or speech therapy or whatever. If a kid needs those services, we'll deliver it, whether they have the additional label of being learning-impaired or not. If they need those services, they're one of our clients.

In those cases where there's a CTC around, some home care programs say, "If we have to buy this, why don't we buy it from an agency that has some experience and a history of dealing with children?" If there isn't a CTC around, the home care program buys those therapies or nursing from any of the other providers, a hospital or the VON or whoever is around to deliver those services. That will continue, and we expect that in many communities the 20% purchasing limit afforded multiservice agencies will be used in those circumstances where a unique or particular perspective or set of experiences or a particular affinity for children might be able to be purchased from an organization such as a CTC. So their funding is secure, to say the least, and the school health support services program will continue to be an important part of the long-term care system.

**Mrs Sullivan:** I'm still not reassured, in that if the 20% limit is exceeded and there is still a demand for services beyond that, there is a huge problem and the only out of that problem is to move to an individual. I understand that CTCs don't exist in every part of Ontario, but it is a big problem. I don't think the ministry has addressed it.

**Mr Quint:** You're quite right that this would pose a problem, particularly in the Metro Toronto circumstance, the example that you used. My understanding of the planning at the district health council level is one that expects that some of the 15 to 20 multiservice agencies in the Metro area will indeed have a specialization.

Perhaps one MSA may have a specialization in dealing with a particular ethnic group and providing services in a culturally sensitive way to that group. Another MSA may well attract those professionals in the system who have a particular ability to relate well with children and to deliver the school health support service program well. For that reason, any purchase from one MSA to the other, whether it's to buy services for children or to buy services for a particular ethnic client group, is excluded from the 20% rule.

In addition to that, they could buy an array of services from an MSA down the road or across town and that wouldn't affect their 20% purchase limit at all. On top of that, they could contract for the services of an individual if it was a highly specialized service and that individual service purchase wouldn't count towards their 20% either.

**Ms Nichols:** I would like to comment that all of that sounds very good, but the bottom line still is that the Metro Toronto district health council, at its series of meetings, reiterated over and over again that it was not allocating anything for children, that it was not setting up a specialized MSA for children, and it still doesn't alter the question I raised about the whole business of consulting people who are currently delivering school-based health support services. It's a good idea to consult them, but it would be better if they were consulted before things were a fait accompli at the Legislature level.

**Mr Quint:** Just to make sure that people don't get the impression that services won't be continued to children, it's my understanding that the DHC is awaiting the review of services at Bloorview and at Hugh MacMillan, and quite frankly, if the DHC recommends a proposal that doesn't adequately serve children, it won't get approved. We expect they're interested in the results of those two studies so they can recommend to the minister the appropriate way to optimize the use of resources for children in Toronto. There's no way in the world we're going to approve a bunch of MSAs in Toronto without the school health support service program being provided in an effective and complete way.

1700

**Ms Nichols:** If I may just ask a supplementary to that, the ministry staff who have attended such things as the special education advisory council at the Ministry of Education and Training have said that children with learning disabilities who currently can have speech-language pathology services under home care will not likely get those services because of the limitation of services to children. What can we look for in terms of services for those children?

**Mr Quint:** You can look for exactly the same level of support for children under the MSA system as they get now under the home care program. There's absolutely no way in which we're intending to diminish the eligibility limitations that are currently in existence for the school health support service program. On the contrary, we hope that the establishment of multiservice agencies and the capacity to have a range of services internal to the agency rather than relying on the brokerage model will allow people to do a better job in meeting those needs.

As I said earlier, our clients in the school health support service program are eligible for our long-term care services, the therapies that are listed in the document. That's what they get now and that's what they'll continue to get if they remain eligible. There's no intention to reduce service to kids as a result of this. The idea is to make services to children better.

**Ms Nichols:** Perhaps if there's another question—

**The Chair:** There is a Hansard record there that I think—

**Ms Nichols:** No, no, I fully understand how to use that information.

**The Chair:** —as they say, is evidence you may take down and use. I regret that with all of the presenters, we have to limit it to one questioner, so I'm afraid our time is up. But I do want to thank you, as always, for coming before the committee, and I suspect you will be before similar committees in the future as well.

**Ms Nichols:** Absolutely. Thank you very much.

ONTARIO ASSOCIATION  
FOR VOLUNTEER ADMINISTRATION  
ONTARIO ASSOCIATION OF DIRECTORS  
OF VOLUNTEER SERVICES IN HEALTHCARE  
VOLUNTEER ONTARIO

**The Chair:** I call on the representatives from the Ontario Association for Volunteer Administration, the Ontario Association of Directors of Volunteer Services in

Healthcare and Volunteer Ontario, the Ontario Association of Volunteer Bureaux/Centres. I almost want to say that you are all here voluntarily, but I won't say it. Welcome to the committee. We have a number of documents in addition to your brief, so if you would just be good enough to introduce yourselves, and then please go ahead.

**Ms Lorraine Street:** My name is Lorraine Street. I'm the executive director of Volunteer Ontario, the Ontario Association of Volunteer Bureaux/Centres.

**Ms Carol Dixon:** I'm Carol Dixon and I'm president of the Ontario Association of Directors of Volunteer Services in Healthcare.

**Ms Lynn Ziraldo:** I'm Lynn Ziraldo, president of the Ontario Association for Volunteer Administration.

**Ms Street:** By way of preface to this brief, I would like to say that we recognize that the language in it is quite strong. Unfortunately, we can't apologize for it. We believe at this point that the language in relation to this discussion has to be strong. We have some very significant concerns, particularly about the role of volunteers in long-term care.

We appreciate the opportunity to present our views before this committee today. Our intention is to raise with you our concerns with respect to voluntarism and the changes to the long-term care system proposed in the bill under discussion.

Our organizations have been offering comments on the proposals to reform the long-term care system since discussions began more than six years ago. When the Redirection of Long-Term Care and Support Services in Ontario was first released in 1990, Volunteer Ontario and the Volunteer Centre of Metropolitan Toronto presented a brief to the senior citizens' alliance hearings. It included the following points, which all three of our organizations now present again as basic issues which must be addressed carefully and completely in the articulation of the newly reformed long-term care system.

(1) While acknowledging that volunteers play a significant role in the delivery of long-term care and implying that the role will be expanded and enhanced in the reformed system, the Redirection of Long-Term Care and Support Services in Ontario and subsequent policy documents do not address the issues attendant upon that involvement. This must happen, we believe, before the system is reformed.

(2) If volunteers are to continue to play an important role in long-term care, adequate resources, both human and financial, must be included in the core operating budgets of agencies and programs. Such resources will be used in the recruitment, proper placement, orientation, training, recognition and ongoing support of volunteers, all of which should be managed by competent, professional paid staff.

(3) The proposed reforms will have a significant impact on the role and function of volunteers, care givers who are informal volunteers and formal volunteers who work for agencies or organizations providing services. Professionals in the management of volunteers and volunteer programs, including representatives of volunteer

centres, managers of volunteers and volunteers themselves, must be given a place at the planning table in order that programs are properly organized with respect to these issues.

(4) There is general confusion and/or disagreement about the appropriate roles of volunteers and paid staff within the reformed system. This issue must be addressed explicitly and as soon as possible in order to avoid potential conflicts between volunteers and paid staff.

The Ministry of Health is currently moving to address some of these issues, in particular through the establishment of a provincial advisory committee on the role of volunteers in long-term care, on which our organizations are represented. Nevertheless, we believe there are other overarching concerns which are not being addressed and on which Bill 173 is largely silent.

We understand that the bill sets out the legislative and policy framework for the new system and does not purport nor intend to provide the detailed structure for it. The concerns we are raising are, we believe, important matters of policy, as opposed to matters of structure or service delivery, and as such should not—should be treated in the bill and not left to the regulations.

**The Chair:** Just to be clear—

**Ms Street:** Just to be clear, there is a "not" there that shouldn't be there: "and as such should be treated in the bill and not left to the regulations."

The first is the nature and role of voluntary action in long-term care services, and I quote from two of the long-term care documents: "Up to 90% of all assistance to seniors and people with disabilities comes from family and friends and not from formal programs" and "Volunteers are the lifeblood of long-term care."

The documents just cited confirm that the place of volunteers and voluntary action in long-term care is enormous indeed. We are therefore puzzled to note that there is one paragraph in Bill 173 which focuses on volunteers and that this paragraph does not establish a legislative or policy framework for the involvement of volunteers in the reformed system. Rather, it provides for the Lieutenant Governor in Council to make regulations "requiring multiservice agencies to develop and implement a plan for recruiting and using the services of volunteers."

We have long urged the provincial government to develop and articulate a policy on volunteerism and would argue that the advent of long-term care reform, whose very lifeblood is volunteers, makes the delineation of such a position imperative and urgent.

The promotion of volunteerism is obviously not the goal of long-term care reform. Nevertheless, this huge endeavour illuminates the lack of consensus in our community about the role of volunteers, perpetuates many of the myths that continue to surround volunteerism, and in particular seems to take for granted the continued participation of volunteers. While we are certain it is unintentional, the documents relating to the reform of long-term care in Ontario seem almost to treat volunteers as warm bodies that can be moved around on a board to suit the needs of the system.

Long-term care reform is built on the notion of the dignity and autonomy of individuals. Indeed, it makes the rights of clients paramount. It also seeks to protect, as it should, the jobs of paid staff who may be displaced in the reformed system. It says nothing, however, about the rights and dignity of volunteers, nor does it make any mention of the fact that the system is built on their work.

Important status is accorded service providers in the bill; important status and protections are promised to homemakers and care givers. However, no such status and no such protections are promised to the volunteers who provide so much of the services. Nowhere in the bill are the rights and responsibilities of volunteers as primary care givers, informal and formal volunteers, spelled out. Bill 173 guarantees immunity from liability to directors and program supervisors but makes no mention of immunity from liability for volunteers, who provide so much of the care.

The question thus forces itself upon us: Why are volunteers seen as so crucial to the reformed long-term care system, yet virtually ignored in the legislation which creates it? If we look at the Advocacy Act in contrast, it is clear in the reports and studies which underlie it, in particular the O'Sullivan report, the Review of Advocacy for Vulnerable Adults, that volunteers are sought to participate in this new system because they bring something that is different, extra, special to the care of human beings. Is this same notion fundamental to the reform of long-term care? If it is, then why is this notion not built into the principles which have been enunciated to guide the unfolding of the new system, and why is it absent from the legislative policy framework?

This seemingly paradoxical treatment of volunteers is typical of the ambivalence of society towards them and their work. On the one hand, they are almost canonized, often to the denigration of paid staff. On the other hand, they are treated as amateurs, viz the often used contrast of "volunteer" and "professional" instead of "volunteer" and "employee" or "paid staff member" and are not included in planning and development, seen as expendable, or, worse, as simply a cheap means to an end.

1710

The great fear of course is that volunteers are seen as indispensable to the reformed long-term care system basically because they are not paid salaries, and therefore a system whose very lifeblood they provide will be, by definition, a cheaper system. Is this voluntary action as providing something essential and different, or is this voluntary action as the tail end of the welfare state, with volunteers filling gaps and being used because "There isn't money to pay people to do everything"?

Our second issue: Who will do what in the reformed system? Here, we and many other professionals in volunteerism would raise questions that parallel those asked here yesterday by Julie Davis of the Ontario Federation of Labour. What are to be the roles of volunteers and the roles of paid staff in the new system? Who will decide what they should be, and according to what criteria? Is it adequate, appropriate or right that these issues should be decided at the local level? Should they not issue from a comprehensive provincial policy worked

out with the complete participation of professionals in the field—that is, in particular, volunteer centres and managers of volunteers—with volunteers, and with labour?

We can say categorically and from direct experience that volunteer/paid staff tensions and hostilities have already begun to surface. This situation will not improve without serious discussion, which we believe should take place at the provincial level.

Again, we recognize that the bill does not set out to detail the workings of the system. We argue that the issue, really the web of issues, surrounding the question of who will do what work is a policy issue and not an issue that should be left to the regulations or to the decision-making of individual communities.

The core of our concern is that, whatever the original intentions and underlying principles about the importance of the participation of volunteers *per se*, the fear is that in these difficult economic times, what will drive decision-making about who does what will be questions of dollars and not questions about who should be doing what or who is best to do what. The fear is that volunteers will become, crudely put, cheap labour. This is both an insult to volunteers and a legitimate concern to labour. This is not just an issue of where volunteers might replace paid staff; it is also an issue of where paid staff might replace volunteers.

What is the real position of volunteers in long-term care vis-à-vis that of paid staff? Are they interchangeable? Are their roles to be determined by rigid rules? Will there be a new hierarchy of positions, with volunteers at the bottom?

A third concern is that of support for volunteer programs. The concern is that established agencies and organizations whose role it is to promote, educate and train etc—that is, volunteer centres, managers of volunteers, associations for volunteer administration—are being bypassed in this reform. We believe they should have a recognized and distinct role in the development of this system which will be based on volunteer services, as this is the field of expertise of these agencies.

In conclusion, we recommend that the government use this opportunity to develop and articulate a policy on volunteerism which then can be built into Bill 173 and other legislation and initiatives. We recommend that the government convene a task force including volunteers, labour representatives and professionals in the field of volunteerism from volunteer centres and from the ranks of managers of volunteers to assist it in the development of such a policy. We recommend that the community resources now available, including volunteer centres and managers of volunteers, be respected and supported, and not supplanted in this new system.

**Mr O'Connor:** Thank you for your presentation. We've heard a lot about volunteers as we've gone through this, and there isn't a member of Parliament, I don't think, in the Ontario Legislature that doesn't know how important the role of volunteers is in each of our constituencies. It doesn't matter what group you go to, there's always a corps of volunteers that is behind it.

One of the suggestions made to us was in part VI of

the bill, where there is the discussion around the board composition of the MSA. Someone had made a suggestion—and I'm going to forget who it was so I'm not even going to attempt to try to remember, but they suggested that maybe in the composition of the board, that portion of the bill would be a proper place that maybe we should place some recognition of the volunteers and the role they are going to play, because they will play an important role. I just wondered if you had any thought to that.

One other portion was in the regulation part. It was mentioned to us I guess by one of the Ontario associations that in the services for volunteers, training should be included in there, trying to work on retention so that, you know, by giving them the training you're going to then recognize that you'll keep the volunteers in place, and some recognition and perhaps even some expense reimbursement if necessary, that maybe that should be included as well in the legislation. I'd just like you to comment on that if you would, please.

**Ms Ziraldo:** I'll comment on one aspect. As far as the management of volunteer resources, one of the attachments you got was the standards of practice that our organization has developed that has been approved by the 300 or so agencies that are involved. So I think that will be very helpful if you definitely include something in the bill, as I would strongly recommend, because there's no way that you can have the volunteers that you're going to have involved with long-term care if you do not have someone managing them etc. So I definitely would stress that you look at this material very carefully.

**Ms Street:** It is standard practice in the field to include resources for proper orientation, supervision, training, screening, recognition, evaluation etc. That is standard practice and should be included.

I'm sorry. I didn't understand the first part of your question, about the boards.

**Mr O'Connor:** Okay. Part VI of the bill describes the MSA. It describes what the composition should be made up of. There's been a policy decision made by the government that it be one third consumer. Some people are saying it should be higher. But it's been placed before this committee that in that portion of the legislation, we should place in there a role for the volunteer in the board—of course, the board will be all volunteers, but something in there that would reflect that the board is volunteers.

I don't know whether you had something you wanted to put in there, because what you'd suggested was that the only time it mentions volunteers is when you go into the regulation part where it talks about the role of the volunteer. It was suggested that maybe in the composition of the board we should recognize the importance of the volunteer. I just wondered if you had something you wanted to add to that section that would recognize their importance.

**Ms Street:** I guess in reading it, the assumption is that in a non-profit corporation the board would be made up of volunteers. It certainly couldn't hurt to add the word explicitly.

**Mr O'Connor:** The other one in the regulation

portion was by the Ontario Community Support Association. They on several occasions have come before us and made that recommendation around volunteers in the regulation portion. Maybe if we can make that suggestion available to you, you can take a look at it and get back later on.

**Ms Street:** Certainly.

**Mr Martin:** Part of the discussion we've had here over the last few weeks re this thing is the question of, why do people volunteer and will we be able to transfer the large number of volunteers who are out there now in the various organizations who are seeing their role diminish to this MSA? I'd just like to hear your comments on that.

**Ms Dixon:** I'm director of volunteer services for the Mississauga Hospital and I know that a great many of the people who come and volunteer at the hospital to work with health care kinds of clients would not be inclined to leave the safety of our big building, knowing that there's always staff there, to go out to people's homes and provide these kinds of services, because there are concerns of the kinds of risks that are there. We have this when we do cross-training with things like Hospice of Peel, and we find that the volunteers who are trained even for them to go into clients' homes sometimes feel more safe in the hospital. So I would say that a lot of our volunteers would not make the crossover.

They're also very familiar with where they're working and what they're doing, and there is certainly a social component to part of why the people are coming to volunteer at the hospital. You'd have to try and take that whole group of things with you when you go.

I didn't explain that very well, but there's a lot more to it than just hiring somebody.

**The Chair:** Did anyone else want to comment on that?

**Ms Ziraldo:** I think my only comment would be the issue that if you're transferring the volunteers etc, how you manage and coordinate that and how you train them will be crucial if they're going to be effective for the consumer, or the client. I think our concern is that as you're transferring them, if that happens, how that training will be done will be crucial. They might be used to specific training on the area of hospice or whatever, and then all of a sudden you're going to put it in one group. Who's going to train them? What kind of training does that person have who's training them? Who's going to coordinate them? Who's going to ensure they're retained? That's where I think most of us would be coming from.

**Mrs Sullivan:** A special mission of the organization.

**Ms Ziraldo:** That's right. They're committed to a certain mission, to a certain belief, and to have it a global, who's going to get lost in that shuffle? I have a feeling that not only will it be the volunteers, but it will also be the consumer and the clients.

**The Chair:** Thank you very much. I think as you know, this has been an issue that has come up—

**Ms Ziraldo:** Several times.

**The Chair:** —different times, but we appreciate the

three of you representing a number of volunteer organizations and the various background documents you've left with us. Thank you very much.

1720

COALITION DE PLANIFICATION  
DE L'ORGANISME DE SERVICES POLYVALENTS  
FRANCOPHONE DU GRAND TORONTO

**Le Président :** J'aimerais maintenant inviter M. Omer Deslauriers pour la Coalition de planification de l'OSP francophone du grand Toronto. Monsieur Deslauriers, vous êtes bienvenu, et vous n'êtes pas seul ; il y a quelqu'un d'autre qui va vous rejoindre à la table. Alors, peut-être que vous pourriez vous présenter aux députés.

**M. Omer Deslauriers :** D'accord. Je vais parler assez lentement pour donner une chance aux autres. Je suis très heureux d'être ici aujourd'hui.

**Le Président :** Les députés sont en pleine forme, alors il n'y a pas de problème.

**M. Deslauriers :** Il y a M<sup>me</sup> Lebeuf, qui est secrétaire générale de RIFSSSO. C'est un organisme dont je vais parler qui est en charge de réunir les professionnels de la santé ou des services sociaux qui travaillent pour des vieillards.

La présentation portera sur un point seulement : l'inclusion dans la loi d'un paragraphe qui voudrait que le Ministre parle un peu de la Loi sur les services en français.

Mais, en général, on peut dire que nous sommes des consommateurs. Nous sommes en faveur du projet de loi 173 et nous sommes très heureux de voir que la plupart des journaux, la plupart des rapports qui ont eu lieu dans votre voyage à travers la province laissent entendre que le projet de loi 173 sera accepté. Donc, les consommateurs sont en faveur.

Ceux qui donnent des services : Il y a 15 ans, on n'avait pas de personnes francophones, tellement, qui donnaient des services aux personnes âgées. Il n'y avait pas d'ergothérapeutes, de physiothérapeutes, d'audiologistes, tous ceux-là. Là maintenant, à l'Université d'Ottawa, il y a un service en français pour former ces gens-là.

Hier, vous avez assisté, je pense, par voie des journaux, à l'ouverture d'un collège francophone même dans le sud de l'Ontario, le Collège des Grands Lacs, qui va nous aider à former des gens pour donner des services aux vieillards, parce que, actuellement, on n'a presque pas de services pour les personnes âgées. On vient d'ouvrir une maison pour les vieux à Scarborough mais il faut aussi voir l'esprit francophone.

La Coalition voudrait vous présenter un paragraphe dans le projet de loi parce que nous trouvons que la réforme des soins de longue durée est une réforme très importante car ça regarde à peu près toutes les personnes de l'Ontario. Par cette loi, le gouvernement cherche à résoudre le fait que les gens doivent passer par tout un dédale pour obtenir et avoir des services. À ce moment-ci, on veut que, par un coup de téléphone, on puisse avoir accès à ces services-là.

Le nouveau service doit être axé sur l'utilisateur. Autrement dit, il doit être d'un accès plus facile, encourager le mieux-être, répondre aux besoins des francophones,

d'après la Loi sur les services en français, et des groupes ethnoculturels.

Le CRSTM, Conseil régional de santé du Toronto métropolitain, est très conscient de la présence de la communauté francophone dans la communauté urbaine de Toronto et a considéré, dans ses différents comités, la planification en incluant les services en français.

Le Conseil recommande la création d'un cadre pour les organismes de services polyvalents à l'échelle de la communauté urbaine de Toronto. On veut 15 OSP et on en voudrait aussi un francophone.

Donc, il est à noter que le Conseil a inclus dans sa demande au Ministre un OSP mandaté pour dispenser des services en français à tous les francophones dans la communauté urbaine de Toronto. Nous voulons même aller à Peel, à Durham, parce qu'on voudrait avoir un endroit où il y a à peu près 100 000 francophones, dans ces régions-là. On ne croit pas que la population de Peel, York et Durham soit assez nombreuse pour donner des services en français ; on pourrait les inclure dans notre OSP de Toronto.

Répondant à la recommandation du CRSTM, un groupe de francophones se réunit régulièrement depuis le mois de juillet pour établir un consortium pour mettre sur pied un organisme de services polyvalents tel que recommandé par le Conseil régional de santé du Toronto métropolitain. Ce groupe a étudié le projet de loi 173 et vous recommande d'amender ce projet de loi avec le paragraphe complémentaire pour conserver un principe d'équité, et d'y inclure l'obligation aux conseils régionaux de santé de planifier les services en français dans les régions désignées par la Loi sur les services en français.

On voudrait, s'il y a moyen, que vous utilisiez la possibilité d'inclure dans le paragraphe 62(1) du projet de loi, juste avant le paragraphe sur les Indiens :

«Lorsque les services de santé d'une région désignée par la Loi sur les services en français est du ressort d'un conseil régional de santé, le Ministre peut enjoindre ce conseil régional de santé de collaborer à sa planification avec la communauté francophone pour assurer les services en français.»

Donc, si on aurait ces services à Sudbury, si on en aurait à North Bay et on en aurait dans le nord de l'Ontario, dans tous les endroits où la Loi sur les services en français existe, le conseil régional de santé pourrait, avec les francophones, discuter de la mise sur pied d'un OSP francophone.

De plus, il est important que la loi soit consistante en français. Le reste n'est pas tellement important. On voit dans la traduction que des fois on parle de «pensionnaire», des fois on parle de «résident». On voudrait, quand en anglais c'est toujours «resident, resident, resident», que ce soit «résident» et non «pensionnaire» ou «résident». C'est mélangé en français.

C'est à peu près tout ce qu'on a à demander. Au fond, ce qui est important pour nous, c'est que votre groupe de parlementaires inclue le paragraphe dans le projet de loi 173 pour qu'on mentionne un petit peu l'effet de la Loi 8, et que dans ces endroits-là où les régions sont

désignées, le conseil régional de santé doit rencontrer les francophones pour discuter des services en français, parce qu'on a un problème. On ne l'avait pas il y a 20 ans, 25 ans. Les francophones, comme peut-être les anglophones, s'occupaient de leurs personnes âgées. Là maintenant, les gens travaillent : le père travaille, la mère travaille. Les personnes âgées sont laissées seules à la maison. Il n'y a personne pour s'en occuper. Maintenant, il faut s'en occuper et ça va vider les hôpitaux.

Vous connaissez tous les avantages du projet de loi 173, et je pense que si le projet de loi 173 va bien, s'il est bien fait, on va réellement assister en Ontario à toute une promotion des services pour les personnes âgées, et puis d'un autre côté on pourra aussi s'en servir comme francophone.

Donc, je vous remercie beaucoup de l'attention que vous m'avez donnée. Je suis prêt maintenant à répondre à quelques-unes de vos questions.

**Le Président :** Merci beaucoup pour la présentation. On passe à M. Wilson.

**M. Jim Wilson :** Merci pour votre présentation. That's the extent of my ability in the French language today. You raise a very good point that's been raised before in terms of the need for a francophone district health council serving Metropolitan Toronto and beyond. You mention that there are at least 100,000 to 175,000 francophones.

**Mr Deslauriers:** We're about 60,000 in greater Toronto, but I think no service will be done in French in Peel or Durham. There are not enough, but with us, it would be enough.

**Mr Jim Wilson:** The way the bill is structured, I really don't know. I don't see that it's possible to have a specific MSA designated. But I do want to give the parliamentary assistant to the Minister of Health the opportunity to respond to this, whether or not it is possible in this legislation. Secondly, what is the intention of the government with respect to serving francophone members of our communities?

**Mr Wessenger:** First of all, when the minister approved the Metro DHC planning framework, she highlighted the need to plan for the ethnocultural communities. Her letter was also supportive of the DHC recommendation that there be a Metro francophone MSA, and that's with respect to Metro.

1730

With respect to the areas outside Metro, a letter has gone out from the minister and the minister responsible for francophone affairs to the DHCs outlining the need for the DHCs to plan for francophone services where they're required under the French Language Services Act. I just point out that in the restructuring of long-term care, this legislation does provide that the services be culturally and linguistically appropriate, so we see this as quite an advance in this area.

**Mr Jim Wilson:** You've seen that assurance from the minister, have you?

**Mr Deslauriers:** For greater Toronto?

**Mr Jim Wilson:** Yes.

**Mr Deslauriers:** No, not yet.

**Mr Jim Wilson:** Was this assurance provided in the form of a letter, did I hear you say?

**Mr Wessenger:** I don't have a copy of the letter with me, but I understand there was a letter sent out.

**Mr Jim Wilson:** A commitment made to ensure there would be a francophone MSA—

**Mr Wessenger:** No, it was a letter that was supportive—I understand there was a DHC recommendation that there be a Metro francophone MSA, and the minister indicated her support.

**Mrs Sullivan:** A francophone representative on the—

**Mr Wessenger:** No.

**Mrs Sullivan:** One MSA?

**Mr Wessenger:** One MSA that would be francophone, yes.

**The Chair:** I'm sorry, just so we're clear, there was a letter from the minister—

**Mr Wessenger:** That indicated her support of that recommendation.

**Mr Jim Wilson:** And what you're requesting the committee today is that there actually be an amendment added to ensure that's the case?

**Mr Deslauriers:** No, if the minister wants to make it for Toronto it's okay for us. We were speaking also for Sudbury, for North Bay, for Kapuskasing and for other places where there are French-language services, I think sections 23, 24, throughout the province.

**Mr Jim Wilson:** I would think that the French Language Services Act is paramount, certainly not overridden by this legislation. So in areas where francophone services are currently deemed to be provided, I would think they also have to be respected in the health care field. Perhaps legal counsel could just clarify that for us.

**Mr Wessenger:** Legal counsel can clarify that, but I believe you're quite right, Mr Wilson.

**Ms Czukar:** Yes, the French Language Services Act is the legislative framework in Ontario for ensuring that services are provided in the French language in those areas that are designated under the act, and the minister has made the commitment that they will be provided in the designated areas.

**Mr Deslauriers:** We want it included in this bill because DHCs are not always aware there's a bill for French-language services and we have to go all over the legislation to explain to people in the DHCs—

**Mr Jim Wilson:** So they're not always—

**Mr Deslauriers:** A small thing in the act that would refer to the French Language Services Act to have services in the French language.

**Mr Jim Wilson:** You are recommending an addition to section 62?

**Mr Deslauriers:** 62, subsection 8.1(5).

**Mr Jim Wilson:** Could legal counsel comment on the proposed amendment?

**Ms Czukar:** I believe that's in the district health council section. I'm not sure what the proposed amend-

ment would be exactly, but district health councils have been requested by the joint letter from our minister and the minister responsible for francophone affairs that they consider the French-language service needs of their communities from the outset in planning MSAs so that when it comes time to have a francophone MSA or an MSA designated under the French Language Services regulations to provide the services in the French language, then they will be prepared for that.

**Mr Deslauriers:** That's what we're asking for. But if it's not in the law, it's a lot more difficult. When we refer to other legislation, it's difficult for them to put it in effect.

**Mrs Sullivan:** Could I just ask a question, Mr Chairman, as a supplementary?

**The Chair:** Point of clarification, Mrs Sullivan?

**Mrs Sullivan:** Yes, it really is. I think that one of the things that's a matter of concern—I suppose Metro Toronto is an issue and I don't know what Sudbury has planned, by example, as to whether there's going to be one MSA for the entire region—but an MSA implies a duplication of services for a separate MSA. I'm wondering if your organization would consider that a satellite of the MSA that has the francophone capacity for service delivery would also be an appropriate vehicle if a DHC chose that approach, rather than a separate MSA for a region.

**Mr Deslauriers:** I would accept this, depending on the number of people who live there. If we are 60,000—some say we are 175,000 in Toronto. I would not vouch for 175,000, but if certain decisions have been made, if we have the numbers, we would like an MSA. If we are not numerous enough we would accept a satellite of it, but as numerous as we are, we think we deserve, and the DHC has approved, an MSA. But in certain places, for example in Thunder Bay, there are not enough. They say, "Come on, you cannot have a French MSA," so other means have to be found to deliver services to the French people.

**Mr Jim Wilson:** In Metro Toronto, because there are large numbers of francophones, you really do need your own MSA in terms of needing that initial contact in the French language and the understanding and culture that go with that.

The way I envision this, and maybe the parliamentary assistant wants to comment, since MSAs can contract with each other for services, could you not set up an umbrella francophone MSA that would provide as much as it could provide of the basket of services in the French language? And then, because contracting with other MSAs is not affected by the 80-20 rule, you could have other services provided by the local geographical MSAs.

**Mr Deslauriers:** What was proposed by the Toronto DHC was 15 geographical MSAs. You're aware of that: three for Scarborough, four for Toronto, but the French one would cover the whole of Metro Toronto.

**Mr Jim Wilson:** I'm just trying to fish out what that might actually entail.

**Mr Deslauriers:** But they may contract with one MSA for services.

**Mr Jim Wilson:** Right, okay. So we're thinking along the same lines. Is that the thinking of the government?

**Mr Wessenger:** Yes, that certainly is the thinking, that for instance a francophone MSA in Metro Toronto could obviously provide services to another MSA in an adjoining area. Also, it should be remembered that in each area where there is, subject to the French Language Services Act, an obligation to provide the services, an MSA would be designated to provide those services in each of those areas. So there would be a designation for an MSA to provide those services.

**Mr Jim Wilson:** A last quick comment: With respect to the amendment that this group is proposing, what are your thoughts on that? Their point is that it sounds like they're constantly re-educating district health councils about what their rights are and they'd like to just be able to point to this act and say, "This act reaffirms our rights."

**Mr Wessenger:** I think it would be unusual to provide for a provision in one particular piece of legislation when you have an all-encompassing legislation that covers all other legislation in the province. Certainly, we can have legal counsel look at the situation to see if there's any reason why it would have to have a specific mention.

**M. Deslauriers :** Merci beaucoup, Charles. Au plaisir de se revoir.

**Le Président :** Merci. Au plaisir de vous voir encore pour une autre présentation devant un comité législatif.

#### CENTRAL EAST REGIONAL GROUP OF DISTRICT HEALTH COUNCILS

**The Chair:** Members of the committee, we are approaching not only the final presentation for today but the final presentation of these hearings. I want to call on the representatives from the York Region District Health Council which, Mr O'Connor, may or may not be an appropriate way to end, but here we are with York region.

We want to welcome you both to the committee, and if you would be good enough to introduce yourselves and then please go ahead with your submission.

**Mr John Rogers:** My name is John Rogers. I am the chair of York Region District Health Council and I'm also here particularly as chair of the Central East Regional Group of DHCs, commonly referred to as CERG. With me this evening is Graham Constantine, who is the CEO of York Region District Health Council and is also the chair of the central-east executive directors' group.

CERG is comprised of members of the six district health councils in the central-east planning area and includes Durham, Haliburton, Kawartha and Pine Ridge, Metropolitan Toronto, Peel, Simcoe county and York region. Its population represents approximately 44% of the provincial total and contains some of Canada's fastest-growing areas. In 1991-92, almost 45% of the total expenditures in health care were allocated to this region. Additionally, it has the largest multicultural population in the province and is challenged by having to meet the needs of large urban populations as well as sparsely populated rural areas.

## 1740

The Central East Regional Group of District Health Councils supports the amendments to the Ministry of Health Act, in particular section 62, since the amendments by and large fulfil the spirit and content of the joint task force report. In 1992, the Association of District Health Councils of Ontario and the Ministry of Health, with the participation of the Ministry of Community and Social Services, established a joint task force.

The purpose of the task force was to define the role and mandate of DHCs, to identify resources required to fulfil their mandate and to strengthen partnerships involved in health system reform. The results of these activities were outlined in the report, *Moving Forward: Strengthening Health Planning in Ontario*. The report was released in the summer of 1993.

The task force concluded that the ability of DHCs to successfully discharge their responsibilities in planning and providing advice to the minister depended on having a clear statement of those responsibilities and their delegation by the minister to DHCs. Many of the issues raised by the joint task force have been adequately and accurately reflected in the proposed legislation.

These issues addressed include the formal recognition of DHCs as a lead planning and advisory body to the Minister of Health, the need to reflect the diversity of the community on DHCs and the recognition that groups other than providers need to be visibly represented. The functions of DHCs outlined in the legislation reflect the actual tasks undertaken by DHCs and the guidance of standardization of composition, recruitment and selection of members of council and committees.

The purpose of our presentation today is to draw to the attention of the standing committee on social development one significant issue that was addressed in the joint task force report but needs to be enhanced in the legislation or the regulations under the act. Under the heading of "Accountability" on page 9, the joint task force report states:

"The accountability of DHCs to both their local communities and the Minister of Health requires them to have latitude in planning for local needs within provincially determined policies, guidelines and standards. In order to function credibly and effectively, DHCs and the ministry must ensure clear channels of communication are established between both themselves and with the local communities. The planning and decision-making processes of the DHC and the Ministry of Health must be defensible to the public they serve, with strong evaluative components built in. DHCs will facilitate strong local input and participation through broad community membership that reflects a diversity of skills, experiences and interests, and through enabling mechanisms to orient and educate council members in fulfilling their responsibilities."

The joint task force report acknowledged a dual accountability of the DHCs to both the local communities and the Minister of Health. In our opinion, the current amendments to the Ministry of Health Act do not adequately recognize the district health council's responsibility to its community.

DHCs have been criticized by DHC detractors as not being locally accountable, on the basis that they comprise non-elected boards. Unless there is a clear recognition by the Ministry of Health of our responsibility to the community, CERG is concerned that our detractors will be able to argue that their accusations have been verified. Responsibility to the community is one of the principles upon which DHCs were built. It should be acknowledged in the legislation.

While the DHC will always remain accountable to the Ministry of Health for providing health planning advice reflective of our local area, DHCs see and must be seen to have a further accountability to the communities they serve. This means that how we do our planning and whom we involve become as important as the recommendations themselves. Ultimately, we will have been successful in our planning processes if the final plans or strategies that are developed are perceived as belonging to the community and not only to the district health council.

While we recognize that we are accountable to the Minister of Health to prepare a plan and identify priorities for our district's health needs, the DHCs also see themselves as having responsibility to the community for the specific contents of the plan. We are increasingly convinced that the key to our success lies not only in strengthening our government mandate, but in improving our linkages with the community.

While the amendments to the Ministry of Health Act strengthen our relationship to the government, there is no counterbalancing acknowledgement of our relationship to our communities.

We would suggest that modification be made to the wording in the legislation or the subsequent regulations so that the DHC's accountability or responsibility to its community is acknowledged. District health councils are more than just another government agency located in a specific district.

In closing, I'd like to reiterate the support of the six DHCs in CERG for the proposed amendments to section 62 and assure you of our ongoing commitment to planning for the health needs of the population we serve.

We appreciate your attention and would be pleased to answer any questions you may have.

**The Chair:** Thank you very much, and I'd just note for the record that the presentation is on behalf of the Central East Regional Group, as much as York region is a part of that.

**Mr Rogers:** Yes.

**The Chair:** Ms Sullivan.

**Mrs Sullivan:** I thought it was Mr Wilson's turn but I guess because he went, we're going backwards. Are we?

**The Chair:** He wanted to practise his French.

**Mrs Sullivan:** I'm very interested in the approach that has been provided to DHCs in the bill, which in fact creates almost an arm of the ministry without accountability to the community, and that's an issue that you have raised.

I'm also quite concerned that in many communities across Ontario, most people don't know what the DHC is, what the powers or responsibilities or mandates are, nor how to participate in putting their information into the process of formulating regional plans to send on to the minister. Your community in York is very similar to mine with both rural and urban components, and I wonder how you see actually making a DHC more accountable to the community and ensuring that the community understands how participation is available to it.

**Mr Rogers:** I think there are a couple of ways to do that, and in any situation you have to determine how well known a particular group or body is. I know when I was involved in politics that they did a study and found out that maybe I was the most recognized person by having 60% of our community know who I was, but the other members of council were down at maybe 10% or 5%; and so even in politics, which is sometimes quoted as being the accountable profession, it's very difficult to get that recognition.

So what we have to do is make sure that when we both form the district health council itself and when the appointments are made to the district health council, you do look at what that particular district is made up as far as the cross-section of the population, the ethnic mix, the geographic locations—all of those things have to be looked at—and make sure that the appointments to council are reflective of the community that that particular council is going to be serving.

Another way of doing the recognition factor is to make sure that you involve as many people in processes as possible, not just the district health itself but the subcommittees of the district health council. In York region, which is a fairly new DHC, which has been in existence for approximately two years now, we've gotten 800 people to participate in different planning processes that we're involved in; and 800 people in our community, even though it's 550,000 at the moment, it doesn't sound like a lot but I think most of you would appreciate that that's a fairly substantial number of people to get involved in health planning issues. They're representative of the provider community, the consumer community, and the municipal governments are involved. We do get a fairly aggressive use of publicity through the media, through local cable programs, those sorts of things that we try to get the numbers of people knowing what a DHC is all about and what their role is to respond and give us their views.

1750

**Mrs Sullivan:** I find it interesting that the district health councils have been given the responsibility, frequently without the resources, to conduct massive planning efforts, and it's not atypical. It could be the Niagara Escarpment Commission in my community, by example, where you want a lot of community participation in determining the future of the plan and only 300 or 400 people are involved and it's considered to be a big victory. I don't think it's a big victory.

One of the things that I'm very concerned about is that the report with respect to DHCs didn't involve the public. It involved people who were in DHCs and it involved

people in the ministry, but there wasn't a broad representation of people who were even asked to participate or comment. It was kind of internal.

There certainly is discussion, through reports such as the Orser report and the Lawson report, of moving into a regionalized funding envelope. Many people see the DHCs as being an approach to moving to that system, and this bill certainly doesn't go anywhere near in that direction. I just think that if those kind of regional plans are ever contemplated, even for a pilot, people have to know what the existing organization does and feel that there's credibility in the community and not just in the minister's office.

**Mr Rogers:** That again is up to each individual DHC perhaps, but citing the example in our particular situation with long-term care, our long-term care committee has had very broad representation in the community. We advertised into the community and made sure that people had as many opportunities—we used every paper, which is eight or nine, in the area to advertise for people who wanted to sit on the committee. We've been going out to open houses and consultation, where we go out to the communities—we don't just sit in our particular location—and do those sort of things. It's not that we're the only ones that do that; a lot of DHCs do that.

The meetings are open to the public, and that perhaps is where the regulations could help, in making sure that there is a set of guidelines that establishes that the meetings are open, that there is some way that there's accountability clearly defined, and that's again through selection of the members, through the ability of people to make presentations or come to the district health council and have their views known so they can be passed on to the minister and allow the decisions to be made by the minister.

**Mrs Sullivan:** I guess one of the other things, if I can just say, that I was disappointed in was that there wasn't, through the legislative process, a larger opportunity for a wider public discussion of DHCs, that the DHC issue is buried in this bill rather than being considered separately, so that we could have public hearings and see where they can be strengthened or where in fact people wanted to see the DHCs going, because it really has been overshadowed by the long-term care issues.

**Mr Rogers:** We should comment that the DHCs, I think, are happy that we were able to get something into legislation—

**Mrs Sullivan:** I know that.

**Mr Rogers:** —because it's been 20 years that we've been waiting and we finally got something.

**Mrs Sullivan:** I understand that.

**The Chair:** Because you're the last witnesses, the Chair is going to allow two more questions.

**Mr Jim Wilson:** Thank you for your presentation. I really do appreciate your comment with respect to wanting a counterbalance and acknowledgement in the legislation about your responsibilities and accountability to the community too, because I have to tell you that—and it's more of a request, and you as a politician may appreciate this—I've surveyed my caucus as Health critic

over the last few months informally about their relationship with DHCs. I think it would be in the interest of DHCs, and perhaps members, but I think it's going to take DHCs to carry the ball on this, to perhaps in the interest of greater community accountability include their MPPs more, because when people are frustrated with decisions by the DHC, they come to us, as you know.

I'm a little frustrated right now in terms of the central-east dialysis study, which has been—not your fault—delayed and delayed and delayed. The reason you're doing that study is because of a private member's bill here by me and other people who participated in the social development committee. I get no feedback from the DHC process and when I talk to individual members, they're to keep it confidential because it's a study and it's advice to the minister.

I wonder on an ongoing and maybe formal way if DHCs—for instance, my local DHCs never invited me in, Simcoe county, in spite of me talking to the executive director and other people. I know they had Mr Wessinger in because he's the parliamentary assistant to Health, but he's not going to be the parliamentary assistant to Health next year. It's just really a plea to—because so many groups come to us every week and keep us informed of what they're doing and I just always wondered why DHCs—maybe you're just too busy; I know you're swamped and there's probably a good reason—don't, like school boards do, invite us in regularly and tell us what they're up to. I think it would be in your interest because a lot of members don't know exactly what DHCs do.

**Mr Rogers:** I happen to have two of our members here in this particular committee, so I think we do try to keep them up and I don't think we've ever had any problems with communication. But I think it's a valid concern that each member should be kept up to date. I don't disagree with that and I think it's something that DHCs should be made aware of. I'd be happy to bring it up; we have an Ontario meeting at the end of October. I'll be happy to bring that concept forward then.

**Mr Jim Wilson:** It's just that we get ongoing newsletters and reams of reports from all kinds of groups out there, and yet when you go to do something on the health side for your community, you're bound now, by soon-to-be-legislation but by the process now, to go through your DHC.

I've said and I'll say it here: Who made the DHCs god? The fact of the matter is, MPPs hold townhall meetings. We have good ideas of what should be done for our health care system and it is somewhat frustrating to think, my God, now I've got to go through this whole DHC process. I can't be a member of the DHC. I could attend the meetings and that sort of thing, but you almost don't want to do that because you don't want to bring undue influence. We're not supposed to go to municipal councils and scream about roads that aren't paved in front of our houses and stuff because we're bound by conflict acts that we lose certain rights to.

So if you could take it back to have them on as regular a basis as they can to just keep members informed, I think it would help all members of the Legislature understand what DHCs are all about.

**Mr Rogers:** Just generally speaking, within the system, there's a manual that's been produced just recently by ADCO, the Association of District Health Councils of Ontario, that is a media-public relations sort of thing. Public relations includes information giving and making sure that things such as newsletters are perhaps generated on a more regular basis so that they can be sent out to members of the provincial Legislature, members of Parliament, to all of the various spots where people would like to at least be kept informed. These are the sort of things going on and if they're interested in a particular issue, then they can call in and deal with it.

**Mr O'Connor:** I appreciate you coming before the committee today. Yes, DHCs have been around for a long time and finally there's a government that's willing to recognize it in legislation. In fact, York region went without a district health council for a long time until the present government saw fit to recognize all the hard work that was done in the community and to see it finally up and running.

It's a pleasure to see you again, John, because quite often York Region District Health Council has made presentations to this committee. So you certainly are well involved within this committee and within the community.

In going along with what Ms Sullivan had suggested, I'm going to give you an opportunity to explain to our viewing audience, whoever may be out there watching, exactly what some of the subcommittees are that people could be involved with in the local planning process, in the local committees that do have a role to play in health care in our communities. Maybe you could share with our viewers exactly what some of those committees are because I think that this is a very important place for the community to have direct input, consumers to have direct input so that you recognize the value of that input as well.

**Mr Rogers:** And I should qualify that you asked me a question on something that is up to each to DHC as to what committees or subcommittees they may have, but as an example, I'll certainly quote to you what we do in York region.

We've looked at the fact that there are so many issues in health care that you're not able to respond to every one of the issues that are out there right at the present time. So we've prioritized, and at this point we have an acute care committee which is undertaking a major study on acute care needs within the region of York, and that committee is certainly open to membership, either right on the subcommittee or we have focus groups, special subcommittees of that committee, to help in specific areas.

We have that particular committee in the acute care field, and we also have obviously in long-term care, it's a major committee at the present to look at the question of MSAs and long-term care within the region of York. That committee's enormous as far as the number of participants in it. The committee itself is, again, reflective of the community and is fairly sizeable: 20 to 25 members.

Then the other major field that we're into is the mental health field as well. There's a group called Co-Ad in our

community that is open to voluntary membership as well as the subcommittee on the mental health reform that's now coming down, and we have membership to that and we advertise for all of those as far as participation from the community.

The other area that we deal with as our fourth priority is the area of healthy communities. That's a little bit more broad-based, but it's to look at how you get people in your communities up to a healthy living standard. That's looking at determinants of health and, once you know how your community fares in the health status reports, then how you improve the areas that need improvement. So those all are open, again, to membership from the community.

**Mr O'Connor:** Thank you very much. I appreciate that, and I think there are a lot of ways that people could be involved in local planning processes through a district health council. I encourage any of our viewers, having heard some of the areas that our district health council has to offer their involvement in, to call the district health council up and do get involved.

**Mr Rogers:** Yes.

**The Chair:** As the Chair and having the last word, I would just simply underline, and I think Larry would agree with this, that perhaps it's partly because you are one of the newest or almost the last, I think, save one, of the district health councils, and I think all the members from all political parties have found that we've been able to develop a good working relationship, and I think that does underline the points that our colleagues made.

Probably one of the interesting things that we will all face—district health councils, legislators and indeed

municipal governments—because I think one of the interesting things that you have done, just to add as well in terms of how you try to represent the community, is the agreement that you have with the regional municipality of York and with the York Region Community Services Council, which I think is aimed, in a large part, at making sure everybody knows what everyone else is doing. I think that as the responsibilities of district health councils have evolved, that broader community sense of understanding and knowing increases, and I suspect that all of us will be involved in that ongoing debate.

As I said at the beginning, you're our last presenters, and that just led us into philosophical areas. But may I, on behalf of the committee, thank you both very much.

**Mr Rogers:** Thank you very much, Mr Chairman.

**The Chair:** And that, dear friends and gentle hearts, brings us to the end of the presentations. I asked the clerk, and I just thought it interesting, in terms of the number of presentations that we've had. We've had 227 presentations but some of those have been joint groups, so we probably have been able to get, between individuals and organizations, something in the range of 250 and virtually all those who did ask to appear before us. So we have gone through our own long-term care, I think, and I want to thank everyone.

Just to remind members that clause-by-clause will begin on Tuesday, October 25, and October 25, 26 and 27 are the scheduled days. I will be in touch with the members of the subcommittee and we'll organize the exact time and some other matters around that. But with that, the committee stands adjourned until October 25.

*The committee adjourned at 1805.*

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York-Mackenzie L)
- \***Vice-Chair /Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- \***Acting Chair / Président suppléant:** McGuinty, Dalton (Ottawa South/-Sud L)
- \*Carter, Jenny (Peterborough ND)
- Cunningham, Dianne (London North/-Nord PC)
- Hope, Randy R. (Chatham-Kent ND)
- \*Martin, Tony (Sault Ste Marie ND)
- \*O'Connor, Larry (Durham-York ND)
- \*O'Neill, Yvonne (Ottawa-Rideau L)
- Owens, Stephen (Scarborough Centre ND)
- \*Rizzo, Tony (Oakwood ND)
- \*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham  
Malkowski, Gary (York East/-Est ND) for Mr Hope  
Sullivan, Barbara (Halton Centre L) for Mr Eddy  
Wessenger, Paul (Simcoe Centre ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Wessenger, Paul, parliamentary assistant to the minister  
Quirt, Geoff, acting executive director, long-term care division  
Czukur, Gail, counsel, legal services branch

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gardner, Dr Bob, assistant director, Legislative Research Service

# CONTENTS

Tuesday 4 October 1994

<b>Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,</b>	
projet de loi 173, <i>M<sup>me</sup> Grier</i> .....	S-2313
Ontario Recreation Society .....	S-2313
Malcolm Bromley, president	
Lynn Briggs, community facilitator	
Catholic Women's League of Canada .....	S-2316
Patricia Beattie, member, Ontario provincial executive	
Moir Ste Marie, member, Ontario provincial council	
Dorothy McGuigan, president elect, Toronto council	
City of Toronto long-term care negotiating committee .....	S-2317
Dr Perry Kendall, chair	
Beatrice Levis, representative	
Elizabeth Amer, representative	
Evelyn Fisher .....	S-2320
Citizens for Independence in Living and Breathing .....	S-2322
Margaret Wagner, representative	
Steve McPherson, representative	
Tom Wagner, representative	
Association of Ontario Health Centres .....	S-2326
Sonny Arrojado, executive director	
Margaret Myers .....	S-2328
Victorian Order of Nurses (Ontario): Durham region branch; Metropolitan Toronto branch:	
Peel branch: Simcoe county branch; York region branch .....	S-2330
Marg Purkis, member, board of directors, VON, Metro Toronto,	
Charles Style, member, board of directors, VON, Simcoe county	
Phil Curtis, president, board of directors, VON, Durham region	
Carole Burtch-Rudderham, executive director, VON, Peel region	
Ontario Chiropractic Association .....	S-2334
Bob Haig, director, government affairs	
David Chapman-Smith, general counsel	
Association of Community Information Centres in Ontario .....	S-2337
Carol Jones-Simmons, membership development coordinator	
Monica Stewart, vice-president	
Pamela Gray .....	S-2339
Canadian Union of Public Employees, Ontario division .....	S-2341
Sid Ryan, president	
Donna Powell, member, health care workers' committee	
Margaret Evans, researcher	
Service Employees International Union .....	S-2344
Judi Christou, assistant to the president, Local 204	
Marcelle Goldenberg, director, research	
Ontario Association of Non-Profit Homes and Services for Seniors .....	S-2347
Dan Oettinger, president	
Michael Klejman, executive director	
Kevin Mercer, president-elect	
Ad Hoc Consumer Coalition on Long-Term Care .....	S-2350
Patti Bregman, representative	
Ontario Association for Community Living .....	S-2353
Cheryl Easton, president	
Jim Mahaffy, first vice-president	
Learning Disabilities Association of Ontario .....	S-2356
Eva Nichols, consultant, advocacy legislation and government liaison	
Ontario Association for Volunteer Administration; Ontario Association of Directors	
of Volunteer Services in Healthcare; Volunteer Ontario .....	S-2358
Lorraine Street, executive director, Volunteer Ontario	
Carol Dixon, president, Ontario Association of Directors of Volunteer Services in Healthcare	
Lynn Ziraldo, president, Ontario Association for Volunteer Administration	
Coalition de planification de l'organisme de services polyvalents francophone du grand Toronto .....	S-2362
Omer Deslauriers, représentant / representative	
Central East Regional Group of District Health Councils .....	S-2364
John Rogers, chair	

C4201  
X67  
-577

Government  
Publications



S-72

S-72

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 25 October 1994

# Journal des débats (Hansard)

Mardi 25 octobre 1994



Standing committee on  
social development

Comité permanent des  
affaires sociales

Long-Term Care Act, 1994

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

*1944–1994*

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 25 October 1994

Mardi 25 octobre 1994

*The committee met at 1014 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Vice-Chair (Mr Ron Eddy):** Good morning, ladies and gentlemen. The committee is beginning clause-by-clause consideration of Bill 173. We will now proceed with amendments to the various sections of the act, and the first is a government motion.

**Mr Paul Wessenger (Simcoe Centre):** I move that clause 1(a) of the bill be amended by striking out "are" in the second line and substituting "is".

I believe, Mr Chair, we're going to suggest that there be agreement that we move all the motions in section 1 and stand them down, in view of the fact that the clerk has recommended that we might want to go back to the purpose clause after we've finished the bill.

**The Vice-Chair:** Discussion on the proposal to read the amendments in and then stand them down?

**Mr Jim Wilson (Simcoe West):** I disagree with that suggestion. I think it is essential that we debate the purpose clause up front, as it sets the tone for the bill.

**Mr Wessenger:** It was a suggestion of the clerk and the Chair that we proceed in this manner. The majority of the committee will decide on this.

**Mrs Barbara Sullivan (Halton Centre):** We're willing to come back to the purpose clause, given the understanding that there must be appropriate time reserved for debate of the purpose clause to ensure that it does receive full debate. I concur that in many other legislative committees the purpose clause is returned to subsequent to debate on other issues associated with the bill, but we feel there is more than one issue with respect to the purpose clause that will require full debate, so we'd like some kind of guarantee that there will be time set aside for the purpose clause towards the end of clause-by-clause.

**Mr Jim Wilson:** Along the same line, although with a note of disagreement with both my NDP and Liberal colleagues: I don't think we're going to have time to get back to the purpose clause, and my fear is that if we don't have time, some of the essential elements of the bill will not be debated fully.

In light of the press conference that's going on right now in the room next door and in light of the 20-odd groups that have formed a coalition to ask for significant

amendments to this bill, we must talk about the purpose of this bill up front. The MSA model that's proposed in the legislation, the prescriptive nature of the legislation, and the inflexibility and lack of community involvement in this legislation—those things are touched on in various ways in the purpose clause, and I think we would be wrong to simply set that aside.

My experience in this committee with respect to advocacy legislation or consent-to-treatment or power-of-attorney legislation is that we didn't have time during clause-by-clause to revisit significant sections of those bills that we set aside at the beginning, and therefore the public were the losers in the long run. Those bills were reported to Parliament I think without full public input and debate.

**The Vice-Chair:** If your agreement is contingent upon further discussion, we would have to require a specific time when we're going to revisit it so that indeed it is. Mr Wessenger, do you wish to comment further?

**Mr Wessenger:** It would be contingent of course on how far we've gotten with the clause-by-clause, but certainly Thursday would be an appropriate time to tentatively schedule revisiting, that it be stood down till Thursday. I think that would be appropriate.

**The Vice-Chair:** Thursday afternoon?

**Mr Wessenger:** Yes, Thursday afternoon.

**The Vice-Chair:** Any further discussion on the matter?

**Mr Rosario Marchese (Fort York):** Mr Chair, could I propose that we spend half an hour to review the purpose clause to get a sense from the members whether they either have objections to what is there or additions they would like to discuss; to take half an hour so we get a sense of what the objections or the support of that might be, and then leave time on Thursday to continue that.

1020

**The Vice-Chair:** You say "discuss" the purpose clause. We've started amendments. We have amendments by all parties, I understand, to the purpose clause, which will be read in.

**Mr Marchese:** I understand that.

**Mr Wessenger:** I think we should first determine whether Mr Wilson is agreeable that we specifically stand this down until Thursday afternoon.

**Mr Jim Wilson:** No, I'm not, and I don't know what gives you any authority to suggest this. I have amendments, as do the other parties, for the purpose clause that

must be debated and introduced now because there are subsequent amendments to them that will come up in other clauses in the legislation; everything flows. I thought our agreement was to proceed as usual in the numerical order, as the bill is printed; therefore our planning and our amendments were put forward in good faith, knowing we were going to go through it numerically.

If, after we have substantial debate on the purpose clause at this time, members feel it needs to be revisited on Thursday, of course at the end of the legislation it may be necessary to come back and spend some time fixing up subsequent amendments to things we may have done in other parts of the bill, fixing up the purpose clause, but it just seems logical to me that we start at the beginning of the bill, as was prearranged.

**Mr Larry O'Connor (Durham-York):** I appreciate the nature and the tone of this discussion, as it's about to lay out how the committee's week is going to go as we go through clause-by-clause. Given that we can't find agreement, I would suggest we just continue, go through the clauses as we arrive at them and carry through our discussion on the proposed amendments; have the discussion and proceed from there.

**The Vice-Chair:** As there is not unanimous consent to Mr Wessenger's suggestion that we just read in amendments to the purpose clause and then stand them down for further debate, we'll proceed. You've heard Mr Wessenger's motion. Is there discussion on his motion?

**Mr Wessenger:** Perhaps I should explain that it's a grammatical change, purely grammatical, the purpose of this amendment. It doesn't in any way change the intent.

**The Vice-Chair:** Any further discussion? All in favour of Mr Wessenger's amendment? Opposed? Carried.

**Mr Jim Wilson:** See? That wasn't all that bad, was it?

**The Vice-Chair:** We'll go to the Liberal amendment.

**Mrs Sullivan:** I move that clause 1(a) be struck out and the following substituted:

"(a) to ensure that a wide range of community services are available to people in their own homes, in community settings and in long-term care facilities."

The reason for including the reference to facilities in this purpose clause is that a significant rationale for the existence of the long-term care reform bill is to ensure a continuum of services. In fact, the placement coordination services will fall into the multiservice agencies; therefore that continuum and the intake must include long-term care facilities.

My view is that there should be a reference to long-term care facilities in the bill in the purpose clause. We've included latterly a definition of long-term care facilities which is identical to that included in Bill 101. We feel this is an extremely important amendment to ensure that continuum, that seamless line of care, is available no matter what place it occurs in.

You will recall that in Bill 101 much of our debate centred around the fact that a person could well move into a facility and then out of a facility to receive care in their home. Without long-term care facilities being added

to the purpose clause of this bill, that full range and that full continuum of services are not considered to be part of the purpose of long-term care reform.

We urge everyone to give consideration to this amendment. We believe it's an important one and urge your support.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I feel very strongly about this particular amendment as well. I take you back to our first week of hearings in Hamilton when this issue came up very strongly. Indeed I was in Hamilton again last week and they are still very concerned. I visited some of the day centres last week. There is no guarantee that those day programs connected with the facilities are going to be intact.

At that meeting—I'm sorry, I don't have the Hansard with me this morning—Mr Quirt suggested that there could maybe be some arrangement, that there could maybe be some exemptions, that these programs would be maintained. But at the moment, the groups involved with these—and certainly the bill itself says nothing to the day programs, which are often the hub, in many communities, of the community services regarding long-term care.

I certainly would like some comments about this and I certainly would like this to be guaranteed so that the people of Ontario, many people in Ontario, would have their minds at ease that the day programs will be intact.

**Mr O'Connor:** This is rather a bizarre amendment. The purpose of the legislation is to take a look at providing community care services within the community. We did deal with the institutional side of long-term care and its reform through Bill 101, and I find rather odd the suggestion that we include institutions in this bill as part of the purpose of this legislation.

The purpose of this legislation is to ensure that the consumers, the people needing the services, are going to receive those services provided to them in a setting of their choice.

In some cases it would include those day programs, and in the majority of cases it would be right in their own private homes. The purpose here is so that the seniors have an opportunity to receive that care, as best as possible, within the community side of this, not in an institution.

**Mr Jim Wilson:** Following on what Mr O'Connor has just said and commenting on the Liberal amendment, in ways it is similar to the PC amendment which will come up next; however, the amendment on behalf of my caucus colleagues goes further.

It's important that a number of groups, like the Sault Ste Marie General and Plummer Memorial Public hospitals and the Metropolitan Toronto Homes for the Aged division, really emphasized with us that we have to have this continuum of care, that we should not, as the government's legislation is worded, be resurrecting or in any way cementing those walls that currently exist between institutions and community-based programs. In fact, I thought when Bill 101 was on the table here last year or the year before—the years are getting blurred here—the whole talk and thrust of long-term care reform

was to take down those walls between institutions and community-based services.

The fact is that in this province—if you take Queen Street mental health services, for example, they are an extreme combination of both community-based services delivered out of what you would look at as their institution down there on Queen Street, but they don't see walls between themselves and the community.

The government's wording in the legislation is problematic, because to me it resurrects walls we've been trying to tear down. In that case I think the Liberal motion doesn't go far enough, and I urge members to consider the PC motion which will come up next. We not only talk about the continuum of care and wanting to make sure there is a continuum of care between community-based services in the non-institutional side and the institutional side, but we also talk about needs-based planning, by saying at the end of the PC amendment that the service be provided "appropriate to their needs," that people's needs be considered. I think that's fundamental too from what we heard from the witnesses.

I would ask people not to support the motion that's on the table right now by the Liberal Party but to sincerely consider the PC motion.

Mr O'Connor, I would ask you specifically to consider what your thoughts were a few minutes ago and think about the fact that it's not going to hurt you in this legislation to send out a powerful message in the purpose clause that we want to take down those walls between institutions, because I think the future of some of our facilities like hospitals will be that they will be the centre, in many communities, for the delivery of community-based services.

1030

I have very strong feelings about the fact that MSAs shouldn't even be established, but we'll be getting into that shortly. But if this government bill goes through—and you have a majority so I expect it will go through—the MSAs shouldn't be out creating new bricks and mortar for their own offices and that sort of thing. We have vacant space in a number of hospitals; we have entire wings that are closed. At Stevenson Memorial Hospital in Alliston in the new town of New Tecumseth, the second floor is just administrative offices now because you've wiped all the beds out. We should be seeing those institutions as a new vision for hospitals, as centres that will also be the headquarters for many of these community-based programs.

If your legislation goes through and people took a strict interpretation of the purpose clause as worded in the government bill, my fear is that it would hinder, actually, long-term care reform and the future vision of the province, which is that we have to tear down those walls. Given that this is the first substantial amendment to the legislation, I would ask you to consider my comments very carefully.

**Mr Wessenger:** We will not be supporting this amendment, for the reasons set out by Mr O'Connor. If we ever move to phase 3 in long-term care, when there's one act, it might be appropriate.

With respect to Ms O'Neill's comments, I would refer her to the amendment we propose with respect to clause 13(2)(a), where we're going to exempt adult day programs from the 20% limit. That, I believe, addresses the problem about the provision of adult day programs by long-term care facilities and hospitals and other facilities.

**Mrs Sullivan:** First of all, I just want to say with respect to Mr Wilson's argument on his motion that comes next that he hasn't read his own motion.

**Mr Jim Wilson:** I certainly have.

**Mrs Sullivan:** His motion talks about non-institutionally based community services. This particular motion is to ensure that there is a continuum that is recognized in long-term care.

I would like to ask the parliamentary assistant where the placement coordinators fit if long-term care facilities are not included in Bill 173. The placement coordinator's role is to ensure that the assessments are performed according to the needs with respect to entry into long-term care facilities.

We are told that the placement coordinators are going to reside in the multiservice agency; that is going to be one of the services the MSA will provide, that they will all fold in. We understand the government has completed the job of putting placement coordination services into place throughout the province now. They are to go into the MSAs, and without this reference to long-term care facilities, in fact they have no authority. I'm asking, Mr Chair, that this motion be stood down for now until we go through the rest of the bill.

**Mr Jim Wilson:** I think Mrs Sullivan asked a question there, if I was listening carefully, and I think it's a good question. Along similar lines, though, I would like a clarification on the Liberal motion with respect to the purpose of specifically mentioning long-term care facilities. To me, in breaking down those walls and in the vision of this bill, we want to make sure the services are available in community settings, which Mrs Sullivan has in her motion. I just want to know what the government's reasoning is, if you could state it once again, for opposing the Liberal motion, and if you could comment on what Mrs Sullivan has just stated, I think that would help clarify where we're headed.

**Mr Wessenger:** If you're asking me to interpret the Liberal motion, I think what the Liberal motion suggests is that community services be provided by long-term care facilities as well as by MSAs. In other words, it's providing a model where service delivery in the community would be institutionally based, and the purpose of this bill is to substantially provide that community services be provided by multiservice agencies, so there's a basic philosophical difference in the approach. That's the way I'd interpret Ms Sullivan's motion.

With respect to her question, the role of placement coordinators was clearly set out in the facilities legislation, which was Bill 101. This legislation merely provides that placement coordinators may be employed by, or will be employed by, MSAs. But their role is set out in Bill 101.

**Mrs Sullivan:** Could I ask the parliamentary assistant

what he meant by perhaps the government might consider this amendment in phase 3?

**Mr Wessenger:** I think the original intention was to perhaps move at some stage to one piece of legislation with respect to long-term care. In that situation, you would obviously have both aspects of institutionally based and community-based services under one piece of legislation, and that certainly is a longer-term goal.

**Mrs Sullivan:** So in the meantime we will have piecemeal bits where nothing's connected.

**Mr Wessenger:** No, that's not—

**Mrs Sullivan:** The purpose and the intent of this amendment is to ensure that that seamless continuum exists. I'm asking, Mr Chair, that this motion be stood down for the time being and we'll come back to it.

**The Vice-Chair:** We'll deal with your request. Did you wish to respond further, Mr Wessenger?

**Mr Wessenger:** No, I don't.

**The Vice-Chair:** Mr Wilson?

**Mr Jim Wilson:** This motion and the subsequent PC motion and the wording of the bill in clause 1(a) speak to the very heart of the multiservice agency model that's proposed by the government. My question to Mr Wessenger, the parliamentary assistant to the Minister of Health, is, have you really considered what you're doing here with your multiservice agency proposal in terms of, you talk about the bill is to provide a continuum of care from facility care to community-based care?

Our preference is to break down those roles even further, but it seems to me that when you're creating monopolistic, large, bureaucratic multiservice agencies—and I note members' sighs when one says that, but it's not me saying that; it's the service providers out there now that you're closing down, like the VON and the Red Cross and Saint Elizabeth Visiting Nurses and many of the members of the Catholic Health Association of Ontario. Literally dozens and dozens, if not hundreds, of groups are affected, and many will simply be put out of business, not to mention the private sector providers right now.

It seems to me, Mr Wessenger, that the bill substitutes a bunch of providers, puts them all into what essentially may be one big institution. Have you thought of that? Because your multiservice agency is not just a coordinating body, but it also must deliver services. I can picture that with many of these community-based services you may essentially be building new institutions in the guise of providing community-based services, because you're putting all these services under one roof. Many will be obviously delivered in the homes, the vast majority, but some, like speech-language pathology and occupational therapy and PT and whatever else is envisioned, may end up being under the roof of the MSA, actually, and be an institution.

**Mr Wessenger:** If I might just respond, it's the clear purpose of the legislation to provide a functionally integrated service delivery model for long-term care in the community, and it's believed that this type of model—it's the government's position that this is the most effective way of delivering service to the consumer.

Certainly, Mr Wilson, others, and your party, may take a view that the market delivery system is the more effective, but our government takes the position that the integrated functional service delivery model is the most effective way of providing service to people in the community, and providing the best service, to break down the fragmentation.

1040

**Mr O'Connor:** What is missing from this Liberal motion I don't support is the reality that Bill 101 dealt with the institutions. It dealt with the institutional care and the reform that was needed for the institutional side of long-term care reform.

What we're debating right now is something that is in the purpose clause of this act, and shouldn't be mistaken at all by any members, that the purpose of this act is to reform the community side of long-term care. The whole objective now is to strengthen access, to improve the way consumers can get that access within the community, so that the consumers now have a better chance for more involvement in the provision of the services.

The creation of bureaucracy: Nothing could be more ridiculous than to take a look at the Metro home care program, a program of \$100 million, and say that isn't a bureaucracy that exists today, because it is; it does exist. What we're trying to do is make that more responsive to the actual consumers. That's what people have said. If anything has been consistent through the entire long-term care reform debate over the last decade, it's been, "Let's make it more responsive to the consumers."

Having a huge bureaucracy that has been there in the past and want to try to create brokerage that's going to make it even more of a bureaucracy is ridiculous. What we're trying to do is to break that down, make it more responsive to the consumers and provide that within the community.

**Mr Wessenger:** Looking at this amendment more carefully—that's the problem of course: You have to make a quick assessment of an amendment. What this would mean is that you would have the obligation of the multiservice agency to provide services in long-term care facilities and place that obligation on the multiservice agency to provide those services in the long-term care facility, while presently we have an obligation on the part of the long-term care facility to provide the services within that facility. We'd in effect be shifting the responsibility away from the long-term care facility to the MSA to provide all these services. That certainly would be a major change in the structure of the way we deliver long-term care presently in this province and be taking an obligation away from the long-term care facility.

I might point out that long-term care facilities now, and in the future, will be able to purchase services from the MSA, if they wish; in other words, to fulfil their obligation to their residents.

**Mr Jim Wilson:** I appreciate Mr Wessenger's comments, but as to Mr O'Connor's comments about Metropolitan Toronto Home Care not being responsive to consumers right now, we didn't get a lot of evidence about that. We heard some testimony from witnesses

during the public hearings about a lack of responsiveness with respect to serving ethnic communities in Toronto, but that was refuted, I thought very well, by Metro Toronto themselves in terms that they admitted they had problems. They admitted, though, that they are working towards coordinating the services and being responsive to ethnic communities.

We had representatives of ethnic communities indicate that they felt they were having more say on how those services were being delivered. That agency is responsible directly to the people through elected representatives, through Metropolitan Toronto council, which is a better model than what you've got here in terms of an MSA, but outside of Metropolitan Toronto and the little bit we heard about the need to be responsive to minority groups, across this province we did not hear that there were a great deal of problems with the delivery of services now. We did not hear complaints about the VON, the Red Cross, Saint Elizabeth and the members of the Catholic Health Association of Ontario, which are the major providers in the province.

In my riding of Simcoe county, in the almost 12 years I've been involved in political life, four of those as elected, I've never had one complaint about the Red Cross, Mr Wessinger, which delivers 100% of the home care services in Simcoe county. So to come out and say that consumers are saying there are problems with the Red Cross in the delivery of services now, that's what we had public hearings for and we did not hear that. Nor did you hear that in your consultation which preceded the development of this legislation. You heard that people wanted a phone number—a phone number is not even mentioned in this bill—as something an MSA must do, and we're bringing in amendments to make sure that something that specific is brought in.

You heard the need for better coordination, but even as we travelled the province, we didn't even hear a lot of anecdotal evidence about seniors being bumped from agency to agency, because the fact is that while there are a lot of phone numbers listed in the phone book—and I grant you that, government—for the VON or, say, the seven non-profit agencies that deliver services in my part of the province, they have for many years been working together and they treat seniors and their clients with dignity and respect. In fact, we didn't hear evidence that seniors are being bumped all over the place.

I think it's a mythology out there. I think that where it may exist it is certainly in the minority of cases where maybe small numbers of seniors have fallen through the cracks. But you want to tear down an entire system because you say you've heard that the current delivery system, that the current agencies that have been in existence longer than our political parties have been in existence—some of these agencies have 100 years of history; you want to tear them down, put them out of business and get government to do it in the guise of a community-based board.

That's what you want to do, and you're doing it on false information. You're doing it on a false, and I think faulty, Price Waterhouse study which, since its release by the Senior Citizens' Consumer Alliance for Long-Term

Care, has been discredited by many, many groups out there simply saying that the data used, the raw data, were wrong, that the interpretation of the data was wrong, that administrative costs in this province for the agencies that exist now are not in the 30% range and that you will not save the \$90 million which you purport to save.

Again, I think it's false. I think it's dangerous to accuse agencies now, whether it be Metropolitan Toronto Home Care or any other agency out there, of not doing a good job and not being responsive, because frankly we didn't hear a lot of that; we didn't hear a lot of need for this legislation as proposed during three weeks of public hearings.

**Mr Cameron Jackson (Burlington South):** As I understand it, this amendment from the Liberals expands the purpose of this bill to include institutional-based care support. I'm a little concerned, just to get back on topic here, that having it in a long-term care facility requires further explanation.

As I understand it, Mrs Sullivan supported Bill 101, which was the institutional-based component of long-term care. I'm wondering if—the fact is that she supported that bill—she's now having second thoughts. Why would she now want to introduce this? Because it fundamentally flies in the face of what clause 1(a) states, which is that it's an alternative to institutional-based care. The definition of a long-term care facility is found in Bill 101. Is Mrs Sullivan, with this motion, suggesting that the MSAs now have representation from long-term care facilities on the MSA board? Should a residents' group in a nursing home now be on the list of potential candidates to serve on an MSA board to represent seniors?

In fairness, I'd like clarification on that; otherwise I think this motion expands it in an area that the bill frankly doesn't get into. The parliamentary assistant has indicated that it is possible for a nursing home to have purchased from an MSA, but if you're going to include them as the front recommendation, then I would like to know, because I haven't examined all the Liberal amendments, does Mrs Sullivan propose later on to give nursing home residents membership on MSA boards, to have the private owners and nursing homes on an MSA board and so on, to be consistent with what she's saying here? If she could help clarify that, I'd appreciate it.

**The Vice-Chair:** Ms O'Neill will speak first and then we'll have Ms Sullivan respond.

**Mrs O'Neill:** Ms Sullivan requested we stand that Liberal amendment down. Was that request granted or denied?

**The Vice-Chair:** No, I have not put the request for unanimous consent to stand it down.

1050

**Mrs Sullivan:** Mr Chairman, I'm going to withdraw that request and move that the motion be put.

**The Vice-Chair:** The request for unanimous consent has been withdrawn. Any further discussion? If not, all those in favour of the Liberal motion to amend clause 1(a) of the bill? Opposed? The motion is lost.

The PC motion, please.

**Mr Jim Wilson:** Mr Chairman, could I have per-

mission to ask the committee to consider both the PC motion amendment to clause 1(a) and our new amendment which would add 1(a.1)? Could I read those together and debate them together?

**The Vice-Chair:** Proceed.

**Mr Jim Wilson:** I move that clause 1(a) of the bill be struck out and the following substituted:

"(a) to ensure that a wide range of community services and service providers are available to people in their own homes and in other non-institutionally based community settings appropriate to their needs."

I further move that section 1 of the bill be amended by adding the following clause:

"(a.1) to ensure"—actually, as I read through this, I probably can't do that.

**The Vice-Chair:** You're actually moving the second one. I thought that you intended to read it in at this time.

**Mr Jim Wilson:** I'll just deal with 1(a) first, please, when I think about it.

With respect to this amendment, it is my understanding that places like Sault Ste Marie General Hospital and Plummer Memorial Public Hospital, and the municipality of Metropolitan Toronto Homes for the Aged division, were some of the groups that wanted this type of amendment, this replacement clause for the government's 1(a). It goes beyond what I think the government's own clause stipulates; that is, we include that not only the services have to be ensured by the MSA in the community but also that the service providers have to be available. It talks about needs-based planning, that you ensure these services are available as a responsibility of the MSAs, as a purpose of the act, based on the needs of the local community, of the community that they're to serve.

While that may not seem on the surface to be all that significant, I think it is significant in terms of health care reform, where we want to move towards needs-based planning. Therefore, we need to ensure that this bill makes every attempt—before, we had simply blanket services in an area, like the mandatory services that are required in the bill—that the needs of those communities be listened to and responded to by the purpose and intent of this legislation.

**Mr Jackson:** As I said earlier, keying in on the phrase "so that alternatives to institutional care exist," I think is inappropriate language. I don't think it's necessary to include that because alternatives to institutional care have always existed and we don't wish to suggest that they're now beginning for the first time in Ontario. The purpose of this section is to indicate the most important component of a purpose clause, and frankly my colleague is correct when we deal with the fact that we're dealing with services appropriate to their needs. That should be the primary focus of this bill, not that the only reason we're having legislation is to have an alternative to an institutional setting.

The concept of need is an important issue here. When we get down into clauses (b) and (c), and in particular (c), you'll realize that this legislation already begins to fall short, because it says "to recognize the importance of a person's needs." That is an absolute meaningless phrase

in legislation. "We will recognize the importance of your needs." You walk in, see a person lying in a bed who needs a colostomy and say, "Yup, you need service," and then you walk out. We have now complied with the bill. What we should be doing is trying to indicate in this legislation, as my colleague in the PC caucus is trying to get across, that we're doing all this so that we can provide services that are appropriate to their needs.

I will want to talk to this section as it comes up in (c) because the whole notion of an assessed person's needs being met is a very controversial issue in this province, contrasted by the government's insistence on removing elements of services that are community based from the Canada Health Act formularies here in Ontario under the OHIP system.

This is a very important key phrase and one which we think should be the focus. If it's going to have any focus for consumers, meaning our seniors in most cases, then we should be saying that these will be delivered in settings appropriate to their needs, and then go on and explain how we will provide services appropriate to their needs. But to simply say that all we're doing is a bill to be an alternative to institutional care I think is misleading and wrong.

**Mr O'Connor:** I found Mr Wilson's discussion around his amendment rather passing strange, because at one point he argued that there needs to be a community level of understanding of exactly what the needs are and the reason and a purpose, so that we can understand it better and plan for it. Then further in the motions that he brought to this committee today, I believe he's got a motion to pull the DHC from there. Here we finally bring the purposes for planning into the future by giving the DHC standing in legislation, and he wants to pull it on the one hand but recognize the need on the other hand.

**Mr Jackson:** On a point of order, Mr Chairman: Could we get Mr O'Connor the actual amendment? Clearly he's not reading from the amendment. The only change we're making is "settings appropriate to their needs," and to be helpful to the discussion, perhaps you could see the actual motion.

**The Vice-Chair:** I believe Mr O'Connor has a copy of the amendment.

**Mr Jackson:** There's no reference to MSA here.

**Mr O'Connor:** I appreciate that when Mr Jackson comes to the committee he does certainly add a little bit of liveliness to the committee from time to time and I appreciate him coming. The fact of the matter is that Mr Wilson did make a suggestion in his comments to the amendment that we are discussing at this very moment, Mr Jackson, that there is a need for planning to take place.

Later on we do have within the package that he provided for us today—I wish he had provided it last week so we could have looked at it a little bit more in depth, but that he brought to us today—

**Mr Jim Wilson:** If it wasn't such a screwed-up bill, I wouldn't have to stay up all this time to come up with those amendments.

**The Vice-Chair:** Please.

**Mr O'Connor:** I appreciate him finally bringing it forward and putting some thought into it. The fact of the matter is yes, there is a need for local planning to take place and the community-based services that we had through the consultation process that we heard from 75,000 people—and we didn't hear from the 75,000 during this process. We heard from a lot of providers that were concerned about where they're going to fit into this, and I would suggest that they be involved in the local process, because it's the local process that's going to define what the needs are locally. I find it rather strange that this amendment would be placed in this way and I won't be supporting it.

**Mr Wessinger:** I won't be supporting the amendment for other reasons as well as what's mentioned. First of all, it says, "to ensure that a wide range of...service providers are available," which would be contrary to the model we're setting of the MSA.

The second concern I have is the words "appropriate to their needs," which would create an open-ended situation with respect to the provision of services, although I do take note of the concern about "alternatives." Certainly I'd be quite happy to accept an amendment, if everybody was agreeable, rather than say "so that alternatives to institutional care exist," to say "so that more alternatives to institutional care exist."

**Mr Jackson:** I wondered when you'd twig to that, because the way it's now printed it means that you can't provide services under this bill, because it has to be an alternative.

**Mr Wessinger:** No, that's not the intent.

**Mr Jackson:** Then why are you putting in your own amendment to add "more"?

**Mr Wessinger:** I think I do recognize the fact that—

**Mr Jackson:** You're dancing with this one.

**Mr Wessinger:** —we do acknowledge that alternatives to institutional care do now exist and we want to make it the purpose to provide more.

**Mr Jackson:** A final point on this from our caucus simply is that the focus is either we want to stay away from a full range of programs, which is alternatives to institutional care, or we want to mention in the first clause service providers and the assessed needs of seniors. That's all we're trying to do, is give the patient, the client, the senior citizen recognition in the purpose clause up front.

The government has chosen to make a reference to what it's cutting and what it's not doing. That's fine; they have the right to do that. But I think the patient should be mentioned in the front section, and what's the most important statement we can make? That their needs be met. That's all we've asked, is that services be appropriate to their needs. If the government would like to imply that inappropriate services will be provided to needs, that's fine, but we think it should be appropriate to their needs in this economy.

1100

**Mr Jim Wilson:** Just ditto on that in terms of "appropriate to their needs" being key. I'm a little disturbed by Mr Wessinger's comment with respect to how he's going

to ask DHCs to do their planning. Again, it's one of the complaints with this bill, that this bill is overly prescriptive. It may in fact be suggesting services that are not needed in parts of the province but are needed in other parts of the province.

This amendment for the first significant clause in the bill simply tries to help the government in setting the tone, which would be that services will not be prescribed out of Queen's Park, that DHCs which are given responsibility for planning and long-term care—but, by the way, not in this legislation; they've already been given this responsibility and this legislation is redundant in that fact—that the tone be set that this is not going to be something dictated out of Queen's Park, very prescriptive through legislation, but that the planning will take place with communities, by communities, and that they will, for a change in this province, tell Queen's Park what their needs are and how best government can respond to those needs.

That's the philosophical tone we're trying to set, and I think Mr Jackson was very accurate in terms of pointing out why we feel so strongly about this amendment and the subsequent amendment to section 1. We could at this point, I think, call the vote.

**Mr Jim Wilson:** Can we have a recorded vote, please?

**The Vice-Chair:** All in favour of the PC motion to amend clause 1(a) of the bill?

**Ayes**

Jackson, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Frankford, Johnson (Prince Edward-Lennox-South Hastings), Lessard, Marchese, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Sullivan, Wessinger.

**The Vice-Chair:** Motion lost.

A government motion to amend clause 1(a.1).

**Mr Wessinger:** I move that section 1 of the bill be amended by adding the following clause:

"(a.1) to provide support and relief to relatives, friends, neighbours and others who provide care for a person at home;"

This motion is really to indicate that the purpose of the act is to provide support to care givers, specifically relatives, friends, neighbours and others, who provide care for a person at home. It's really to alleviate the concerns of some presenters who said that care givers were not included in the bill. We want it made very clear that it's the purpose of the bill to provide that support for care givers.

**Mrs Sullivan:** We will be supporting this amendment. We think it's a good one and in fact an important one. One of the things we certainly heard during the course of the committee hearings was that while it appeared that respite services were included in the definitions, it wasn't obvious to people that those services were highlighted and were to be an important part of the community-based care.

We feel that by adding additional emphasis in the

purposes clause to the need for respite care not only for the family care giver but for the neighbour and so on, we will meet a lot of the felt need of people who will be served. As well, it's a signal to the MSAs that those services are considered to be a priority for their operation. We think this is a good amendment. We like it and we'll be voting for it.

**The Vice-Chair:** Mr Jackson, did you wish to proceed now?

**Mr Jackson:** Mr Chairman, I realize we're dealing with legal language here, so I want to make sure that somewhere further on in the bill this new purpose section is clarified satisfactorily so that "multiple services" may not necessarily be applied. We support the principle of this, but I just want to make sure the legal language that surfaces further in the bill is such, because this is loosely written.

It's in the purpose clause; I can accept that. But it's loosely enough worded that it implies that somebody can receive respite services from a whole host of neighbours and everybody else so that the primary care giver can be away for months on end. It's loosely worded. I'd like to know where in the bill it resurfaces so I can be satisfied that it's not as loosely worded as here. A great idea, but I could see abuse if it's not tightened up in the bill.

**Mr Wessenger:** I believe we're dealing with paragraph 12(1) and the subsequent amendment, which provides that a multiservice agency shall provide or ensure the provision of a range of community services mentioned in subsection (1) for palliative purposes and arrange for community services mentioned in the section for respite purposes in the geographic area for which the agency is designated. Also, the definition of "care giver support services" includes providing information, respite and other assistance to care givers to support them in carrying out their care giving responsibilities.

**Mr Jackson:** Will the regulations be amended or will they reflect—I'm sorry. To reiterate, my concern here is that it is possible for an individual who's being cared for by one other individual to bank up a ton of respite by just involving—one neighbour does it for one week, another neighbour does it for another week, a friend comes in and does it for a week. These are limited respite dollars, I'm told, and they could go very quickly if someone interprets this that everybody on your street would be eligible as long as you're putting in a little bit of time to help grandma.

**Mr Wessenger:** Perhaps I could indicate that definitely the intent and the policy would deal with the primary care giver in a sense, but I think that in some instances a primary care giver often is a person who would fall in the category of a friend. Really, it's a primary care giver, not someone who provides just temporary relief.

**Mr Jackson:** I want to be careful, because we should really say "primary care givers" and then define later. But you start writing that neighbours and friends and acquaintances and the milkman and all these other people could potentially be eligible for respite because they help out—I just want to make sure the regulations will clarify that, what's a primary care giver, and that this is not a hierarchy of respite services.

**Mr Wessenger:** This is a purpose clause, not eligibility criteria.

**Mr Jackson:** I'm not asking about the purpose clause. I'm asking about where it surfaces in the bill and in the regs.

**Mr Wessenger:** I'll ask legal counsel to indicate where the eligibility criteria are in the bill.

**Ms Gail Czukar:** The specific eligibility criteria will be set out in the regulations. What the purpose clause is meant to do here is to be inclusive about the definition of who may be the primary care giver. It will be clear in the eligibility criteria who the primary care giver is and what kinds of supports they would qualify for.

**Mr Jackson:** Normally, we usually say "or their designate" if you've got a primary care giver or their designate, or they indicate "in accordance with the wishes of the recipient of the services." It's just that it's an unusual way of writing it. It's sort of like a catch-all, with a whole list of people, whereas normally legislation—if we go to Bill 101, the references were made to "or their designate" and/or to "a person chosen by the person receiving the care."

**Ms Czukar:** Those kinds of specifics would be contained, again, in the regulations that would deal with the eligibility of people for the services.

**Mr Jackson:** Okay. Thank you.

**Mr Jim Wilson:** I think this is a good amendment put forward by the government. I know we've attempted throughout other parts of the bill and in this section to do similar things. I agree with Mr Jackson that the wording may be somewhat problematic and open to a wide interpretation as to who's encompassed in "friends, neighbours and others." However, I'm prepared to live with that.

I also appreciate the government's subsequent amendment in section 12, because we did have a lot of groups that weren't satisfied that the only mention in the bill as written for respite care was simply in one section and we were told time and time again that that wasn't sufficient. So I'll be recommending that we support this particular amendment.

1110

**Mr O'Connor:** I'm glad and pleased to see the support coming around the committee room. It's refreshing and I hope it continues as we go through these three days of clause-by-clause.

I think it's important to recognize that this was an area that did receive some considerable amount of importance placed before us by the presenters, who felt that respite needed to be recognized, and respite doesn't always mean the care giver is a family member or spouse. So though it may seem like it's open-ended, I think the important thing here is to recognize the importance of the respite care.

I believe as we move forward and get to section 12, it further clarifies the role and the importance of respite. Most certainly this was the intention all along, but it was certainly felt it was unclear as we went through the committee hearings. It's important that we do place it, and that's why I will be supporting this amendment.

**Mrs Sullivan:** I just want to be very certain, and legal counsel can assist us here, does "relative" include spouse?

**Ms Czukar:** Yes.

**Mrs Sullivan:** Okay, great. That's terrific. Let's vote.

**The Vice-Chair:** All in favour of the government motion to amend clause 1(a.1)? Carried.

PC motion, 1(a.1).

**Mr Jim Wilson:** With the passage of 1(a.1), we'll number this amendment 1(a.2).

I move that section 1 of the bill be amended by adding the following clause:

"(a.2) to ensure the integration and coordination of community services with established institutional frameworks including acute care facilities, chronic care facilities and mental health facilities."

Again, as I was saying earlier, the linkages throughout the health care system are of vital importance, and I think the failure of Bill 173 to integrate with other areas of reform like mental health reform that are also going on at this time is problematic in this legislation.

Now, Mrs Sullivan's first amendment, which talked about the availability of services in institutional settings, long-term care facilities, I think was different, although I think trying to get at the same problem, and that is the lack of continuity between settings of care in Bill 173. I think the Liberal motion was just a little off and that this one attempts to put in the purpose clause the need for integration and coordination of community services with established institutional frameworks.

We've worded it that way so as to include as much of the institutional side of the equation as possible and again to ensure that the legislation breaks down those walls between institutions and community. That is the intent of this section. I hope members can support the wording and intent, although I am open to any suggestions if the wording is problematic for some members.

**Mr Wessenger:** I would point out that there are some amendments, first of all clause 1(c.1) of the bill, which provides integration of community services that are health services with community services that are social services, and then clause (g.1), which is to promote cooperation between providers of community services and providers of other health and social services.

I feel that there would be, as Mr Wilson says, perhaps some problematic difficulties with the language of his amendment and I believe the amendments that we will be moving would cover the aspect of ensuring the cooperation between all the health and social service providers in the community. I believe cooperation is a more appropriate language for that aspect.

**Mrs Sullivan:** This motion is basically comparable to the first motion we put, where we were quite concerned about the continuum. While the wording of our first amendment may not have conveyed the coordination role, that certainly is what we were looking for: to ensure that the facility-based services are coordinated with the community-based services so that seamless continuum I spoke about earlier is ensured.

I would be interested in seeing an amendment to this

that would say, following "mental health facilities," "and in long-term care facilities," which seem to be left out. I think this is a useful amendment with that.

I would then like to move that section 1 of the bill, as proposed to be amended by clause (a.1), be further amended by adding the words "and in long-term care facilities."

**Mr Jim Wilson:** Just a correction: The rewording numbering is (a.2).

**Mrs Sullivan:** The clerk will look after that.

**Mr Jim Wilson:** But I read it in as (a.2).

**Mrs Sullivan:** I see. The reason for this, once again—and I understand that the government motion later on is comparable—is that the emphasis on the coordination of services is extremely important. I am disturbed when the parliamentary assistant says that kind of coordination is going to be left to phase 3, which would entail a new piece of legislation, when we know that the MSA is going to have placement coordination services that are supposed to assist the individual with the assessment and placement in a long-term care facility, and that the many people who require long-term care services in the community also have to link with institutions for certain kinds of care, whether it's dually diagnosed or people with long-term care facility requirements that may be short- or longer-term.

I think this is a useful amendment, and with our amendment to it we would support it.

**Mr Jim Wilson:** I'm quite prepared, as Mr Jackson is, to accept that as a friendly amendment and incorporate it into the PC motion, if that's okay with Mrs Sullivan.

Secondly, I want members to consider again why this motion was worded as such and why we delineated such things as mental health facilities. We do not want to see once again what is currently going on in the province, and that is the deinstitutionalization of mental health patients thrown out on to the street. This is three governments now that for 15 years have been throwing people out on the street without having the linkages to community-based services available for those people, the opportunity to be discharged into a community-based setting.

What this amendment does, if you look at the wording carefully, with respect to integration and coordination, is that it places some responsibility in our system. Bill 173, as concocted by the government, leaves mental health totally out of the reform of long-term care at this point. I think that's wrong, given that you're setting up a model where the MSAs have a monopoly on delivery of services.

Your own mental health reform documents talk about the MSAs being part of the delivery of community-based mental health services, being the facilitators and coordinators of delivery of mental health services in the future. Today is the first time I've heard about phase 3 of long-term care reform, but I guess in the big bureaucracy over there in the current government they've decided phase 3 will try to patch up what 1 and 2 missed. It's getting to be the continuing saga of nonsense. A lot of people are being discharged now, with \$56 million, I think it was, taken out of mental health facilities, beds

closing as we speak, people being discharged.

The key ingredient that is missing is that there are some community-based services out there—granted, there are—but nobody takes responsibility. When you're a psychiatric patient in a facility, the physicians and health care professionals of that facility have a legal responsibility to look after you. Upon discharge, you're on your own. The government's attempt in the past was to beef up the advocacy army out there to make sure these people had voices in the community to find the services. We've rejected that as being the most effective model.

1120

What you have an opportunity to do here in the purpose clause is to say that MSAs, which have the responsibility of upholding the purposes of this bill, must provide for and take some responsibility upon discharge of the mental health patient. Therefore, the physicians or health care practitioners currently operating in the mental health facilities, in our mental health hospitals, can phone the MSA and say: "The government's closed 10 beds. I've got to discharge some people, but under Bill 173 you have a responsibility to integrate and coordinate your services with ours. Let's get together and let's make sure people just don't end up on the street."

By putting this in the purpose clause, I think we finally do something towards putting responsibility on a quasi-government agency like the MSA. Right now, what's missing is not necessarily the services; there are many services in parts of this province. People who are discharged from mental health facilities don't find themselves receiving those services or finding themselves with the information to access those services.

This would ensure—it's an attempt, anyway, to ensure—that in addition to all the other stuff we talked about, the continuum of care, it would also put some responsibility on the MSAs. I think the effect will be dramatic. I think the effect will be that you won't be so quick to close the institutional beds, because you know MSAs will now have a responsibility to look after those people so that they don't go out into la-la land with no government agency responsible for them. I bet you'll soon be reviewing your policy with respect to closure of beds. Right now you're repeating mistakes of past governments: You were holier than thou, hanging from the chandeliers in the past in the Legislature, when you were in opposition, about the discharge of psychiatric patients on to our streets. You have a golden opportunity in this legislation to do something about it, to put some responsibility into the system. I would ask you to consider that, in addition to the continuum-of-care arguments we made earlier with respect to this clause.

You've left mental health out of this act, and I want to know, if you won't support it, Mr Wessinger, what are you doing for those mental health patients, whom you're discharging as we speak, from Ontario's psychiatric hospitals in terms of making sure that services are provided for them in the community and that some agency has responsibility for these people, so that if someone falls between the cracks we won't have any more coroners' inquests trying to figure out what went wrong? We'll be able to go to the MSA and say: "You

had responsibility for this individual. You failed in your responsibility and you will suffer the consequences." I think it's a vital part of the system, that's currently missing. Somehow we've got to get it into this legislation and not let this opportunity pass us by.

**Mr O'Connor:** I appreciate this amendment coming from my PC colleague. It certainly is interesting. I believe as we move forward you'll note that in some of the government amendments we have before us the type of cooperation that he's suggesting needs to take place between the health services and social services is actually recognized. I think this just reinforces the necessary planning role of DHCs. The need to plan for the mental health reform within our communities is certainly most important, and that just points to the very real reason why we need to make sure we enshrine the role of the DHCs in the coordination and planning roles they do have within our communities in terms of health care.

As we proceed, I think we'll appreciate his intention here. I think it has been covered off quite well. I appreciate the fact that he supports integration. This bill is all about integration of long-term care for the seniors in the community. I appreciate that Mr Wilson is coming forward and supporting integration of long-term care; that's important to note. I can't support Mr Wilson's amendment, as proposed, but I'm certainly pleased that he supports integration and the planning roles for health in our communities.

**Mr Jackson:** First of all, I want to support Ms Sullivan's inclusion because I believe it's appropriate here when we talk about coordination, not about how we don't want our health services to be constructed. I think it's a more positive way to place it.

Secondly, I can't underscore enough the importance of the words "integration and coordination," which are missing in the government's legislation. I want to remind members that the Ministry of Health is now controlling this entire turf. Bill 101, within the regs, saw a major conversion of a whole number of facilities from the Comsoc ministry into Health; therefore the concept of coordinating on a continuum is incredibly important. I note that the government separates the notions of "integrate" and "coordinate" through its motions, and I don't think that's necessary. It's almost as though they'll only coordinate some activities and only integrate others, and I think that's inappropriate.

I think it's clear why the NDP government is refusing to do anything sensitive and appropriate for mental health facilities and services. I recall having sat in opposition alongside Richard Johnston and David Reville. It was clear what their agenda was. Now I suspect that Mr Reville, as an adviser on health policy to the Premier, has changed his focus. He not only has changed the direction on mental health services, he's also secured himself the appointment as the advocacy chair. By not supporting this amendment, the government in fact creates a whole marketplace for him and his \$30-million bureaucracy.

I believe what the Conservatives are trying to do, with the support of the Liberals, is say, "We will support the MSA model, we will support a coordinated and integrated effort, but let's not shut out mental health patients from

the process of coordinating services in their communities under the MSA umbrella." As long as the NDP refrains from supporting this, it will create millions of dollars worth of bureaucratic work for Mr Reville, for him and the vice-chair, who also comes with this philosophy on how they're going to approach mental health care.

In my view, the government's political will to be supportive here is blocked by the political imperatives to make sure that Mr Reville has enough work with this incredibly expensive Advocacy Commission. We see that as unnecessary duplication. We see it as being primarily intrusive to their lives instead of being supportive.

I can't help but suggest that Mr Wilson's recommendations here are very clear and very spot on. Bottom line, that's exactly what deputants who came before this committee pleaded with the government to consider, but it's chosen, behind closed doors, to go with Mr Reville's view. Unfortunately, we can't support that, but the government has the right to do that to those persons in Ontario needing mental health coordinated services.

**The Vice-Chair:** Mr Wessinger, did you wish to speak to the amendment?

**Mr Wessinger:** Just to indicate that we won't be supporting the amendment and to indicate that putting in a purpose clause doesn't really ensure that what's in the purpose clause takes effect, because it depends on what's in the body of the bill. I certainly have problems, particularly with the words "to ensure." I think our language, "to promote," is better than "to ensure," because it's more reflective of the legislation. I think the fact that we have moved the two amendments will more effectively represent the provisions of the bill.

**The Vice-Chair:** All in favour of Ms Sullivan's amendment to the PC motion to add clause 1(a.2)?

**Mr Jackson:** Recorded vote, Mr Chairman.

**Ayes**

Jackson, McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Frankford, Johnson (Prince Edward-Lennox-South Hastings), Lessard, Marchese, O'Connor, Wessinger.

**The Vice-Chair:** The amendment is lost.

Back to the PC motion to amend—

**Mr Jackson:** Recorded vote, Mr Chair.

**The Vice-Chair:** All in favour of the PC motion?

**Mr Jackson:** Same vote?

**Clerk of the Committee (Mr Doug Arnott):** Mr Wilson, Mr Jackson, Mr McGuinty, Mrs O'Neill, Ms Sullivan.

**Mr Wessinger:** Same vote.

**The Vice-Chair:** Same vote? Opposed? Motion lost.

A PC amendment to section 1(b).

1130

**Mr Jim Wilson:** I move that clause 1(b) be amended by adding "physical and mental" before "health" in the second line.

The Canadian Mental Health Association, the Ontario Psychological Association, the Association of Ontario Physicians and Dentists in Public Service, Alzheimer Association of Ontario and others all expressed concerns about the lack of attention to mental health and wonder how they fit into long-term care, how the mental health reform that is going on in any way links with this reform of long-term care. Therefore this amendment tries to ensure that some qualifiers are put in before the word "health" so that we are very specific in this legislation that the purpose of the legislation is to deal with physical and mental health of an individual.

Mr Chairman, I want to read for committee members and for the public viewing this proceeding what clause 1(b) would now say. As amended, it would read:

"(b) to improve the quality of community services and to promote the physical and mental health and wellbeing of persons requiring such services."

I think it's a necessary amendment. There's a great deal of discussion, as you know, Mr Chairman, in the health care sector these days about what is "health." Anything in this bill that helps to qualify the terminology of "health," and in terms of the purpose of the act and the responsibility the MSAs will have, I think helps to further the debate of what "health" is. Therefore I think it's necessary to put in "physical and mental health."

It also gives the opportunity once again for the government to signal in the purpose of this legislation that mental health is important, that it is foremost on the minds of the government and that it will not be left out of long-term care reform. We are attempting here to advance the mental health agenda at a time when mental health in this province is at a crisis because of the deinstitutionalization that's going on; therefore I would ask the government to seriously support this amendment.

**Mrs O'Neill:** I think this is a very important amendment. We heard over and over again that the needs particularly of seniors in the province are very dependent on their mental health, and often their mental health is more than directly related to the state of physical health they're experiencing.

Several times, certainly in an interview I've just read this morning that the Minister of Health, Ms Grier, has given, she talks about treating the whole person and that that's what the goal of the MSA is. I really do not know how Bill 173 can deal with the whole person if mental health is not included.

Right from the very first day this bill was presented and we began to have the hearings, we heard from people across this province that they are seeing a real void particularly regarding psychogeriatric care. I will certainly be supporting this and any other motion that comes forward as an amendment regarding mental health being included in Bill 173.

**Mrs Sullivan:** I was quite taken with this amendment. As you know, throughout the hearings we have been quite concerned about how the mental health reform and the long-term care reform are going to come together. I recall the presentation of the municipality of East York and the very tragic tales they told with respect to the

desperate need within the long-term care continuum for the availability of crisis intervention services. We heard about the helplessness the board of health felt in dealing with a person who ultimately died in tragic circumstances and a couple of other cases.

I got those cases and I read them and I found out what had occurred and where the linkages in fact had fallen down, and by specifically saying that the physical and mental health considerations have to be taken into account in service delivery, and particularly in crisis intervention but in those situations my colleague Mrs O'Neill has mentioned with respect to the psychogeriatric illnesses, we feel that there has to be a coordination and that there has to be a signal that that coordination and that linkage will exist.

So we support this amendment. We think it's a valuable one.

**Mr Wessinger:** We will not be supporting the amendment, for a couple of reasons. First of all, if we look at the concept of health, I think it's fair to say that health includes not only physical health but also mental health, and the definition of health would include that. The concern of specifically putting it in is that I think it would raise the expectations that this act would provide mental health services. That's the concern, of raising a false expectation that the bill would deliver something that it's not set out to deliver. That's my concern about putting the language in, not the fact that health would include the physical and mental health of the individual.

**Mr Jackson:** Is the parliamentary assistant to the Minister of Health familiar at all with the Putting People First document on mental health reform his own government has undertaken? Are you familiar with that document?

**Mr Wessinger:** I—

**Mr Jackson:** It's not a tough question, Paul.

**Mr Wessinger:** I am somewhat familiar with what is undertaking it.

**Mr Jackson:** You are somewhat familiar with it. Are you familiar that within that document they are recommending these kinds of coordinated continuity of services within an MSA framework? Are you familiar that there is reference in that document from your own government?

**Mr Wessinger:** Yes, but I would point out the purposes. If we look at (c.1), it's to integrate community services with other health services, and also to promote cooperation in (g.1). I would suggest that that certainly—

**Mr Jackson:** Well, those are all weasel words used by politicians, but we haven't hit down the point of mental health, and nowhere in the purpose document do we talk about mental health, so I'm going to ask you again: Were you present for the public hearings when the Canadian Mental Health Association, the Ontario Psychological Association and at least the Alzheimer Association of Ontario presented their case, cogent arguments for this, and you at the time gave them really supportive kinds of words, but why is it that now at the 11th hour, with the bill laid open before us for amendment, you've come to the conclusion that it's unnecessary to make any refer-

ences to them? Could you tell us now why you've changed your mind from when these groups were sitting right before us, many times right in this very room?

**Mr Wessinger:** I think we don't want to create any false expectations with respect to what this bill is doing, and that's—

**Mr Jackson:** So those services won't be coordinated then?

**The Vice-Chair:** Please, one speaker.

**Mr Wessinger:** Yes, there's certainly the interest in having coordination and integration of services.

**Mr Jackson:** They just won't be funded. Is that what we're to take from that? It's one thing to expect service, parliamentary assistant.

**Mr Wessinger:** I think it's fair to say they're not being provided under this legislation. That doesn't mean there is not a plan to have the whole mental health reform system work.

**Mr Jackson:** I want to bring to the parliamentary assistant's attention one in particular, one case. I know Elinor Caplan has visited this location. I know Frances Lankin, who was the minister who was primarily responsible for constructing the positive elements of this bill, when she was still on a brokerage model, visited this location. Mr Wilson and I have visited this location. That's Senior Link up in the Danforth area. They provide probably one of the best examples in Metro Toronto of the kinds of coordinated issues which my colleague is putting forward in this recommendation.

It's bad enough that Senior Link, under your legislation, will not be considered as a potential MSA when in fact it could be one of the best we could have in this province. But more importantly, they came forward and told you that nowhere can they find the direct reference in the legislation, so they see many services they currently provide being removed as a result of this absence of reference.

1140

Parliamentary assistant, if that's your game plan, then come clean and tell us. Would you please clarify why you want to lower the expectation that the services you'll phase out with Senior Link are no longer going to be available in this legislation, on behalf of Senior Link? I would simply ask you to support the amendment so that we could give truth to your words that in fact within the legislation they will be protected. If you want to lower their expectations, then vote against this amendment.

**Mr Wessinger:** I'd like to assure you that there's no policy to take away any services that are currently provided. Since you've raised the issue, I'll ask Mr Quirt to indicate what is now provided in the long-term care system with respect to these types of services.

**Mr Geoff Quirt:** Mental health services in particular?

**Mr Wessinger:** Yes. How it relates to the long-term care services; how we presently work.

**Mr Quirt:** At this point in time, the long-term care system provides for the needs of all clients who require services like homemaker services or visiting professional services, whether they be nurses or therapists. It's quite

often the case that clients of the long-term care system are also clients of other service systems. In other words, someone may have a mental health problem and be receiving services from a psychiatrist or a community mental health centre as well as receiving the services of a nurse or a therapist because of their generic long-term care needs, in the same way that sometimes someone with diabetes who is elderly and lives at home would require our generic support services to maintain an independent lifestyle, and would also receive specific services to deal with their diagnosis of diabetes. So our long-term care services are generically available regardless of whether someone has a specific condition that requires intervention from another particular discipline or a particular perspective.

**Mrs O'Neill:** I'm really finding this extremely difficult. From day one here, everything around here has been in a veil. It's been mealy-mouthed. There's no commitment. One person, the parliamentary assistant, says one thing and the director of long-term care says something else, all of it very unspecific. People who came before us are in real situations and most of us know there are real situations.

Mental health is either in the basket of services or it's not. Mental health does not necessarily involve a psychiatrist. There are other people who are very involved in mental health, whether they be case managers, in some cases giving the proper assessment, and the proper quality of care being continued.

I am finding it very difficult that the people in this province cannot be told whether mental health is included or not. The parliamentary assistant has just said, "Yes, 'health' does include mental health," but there's nothing in this bill. He's not supporting the amendment that would say so. On another occasion, again I think it was that ominous day in Hamilton when we had the technical briefing, I think I was told that an MSA may purchase mental health services if all the other services that are mandated in this bill are fulfilled. So where does it come? It looks like it's at the bottom of the list at best and may be outside totally.

**Mrs Sullivan:** I'd like to go back to clause 1(b). This section of the bill starts out by talking about "to improve the quality of community services," and then it talks about "and to promote the health." The parliamentary assistant has indicated that "health" here is understood to include physical and mental health, but then he goes on to argue, "However, we don't want to raise expectations that in fact physical and mental health will be covered," basically hide the fact that mental health is included, that the health promotion activities associated with mental health should be hidden because we don't want people to believe that those kinds of services are going to be provided. I suggest to you that this bill applies to children, it applies to seniors, it applies to people who are disabled.

The acting director has indicated that people may source mental health services from another vehicle or from another place. What that tells me is that when the parliamentary assistant says that physical and mental health are included in this bill, what in fact is happening

is that they are not included in this bill and that a person, say, a teenaged child who is disabled after a car accident and needs long-term care, and as a consequence of that particular situation also needs assistance in coming to terms with perhaps the loss of a leg, head injuries or other disabilities—what we're now being told is that mental health promotion and assistance is not going to be delivered through the MSA, that in fact there is going to be another access point for those services to be delivered.

For holistic, the whole-person care that the minister talks about, the appropriate place for those services to come into play is at the same time when the other long-term care facilities are being provided to that particular individual.

The amendment is a simple one, but it does highlight the fact that those health promotion activities—I spoke earlier about the crisis intervention issues that may well be associated with other long-term care services delivery—should be highlighted. I guess that's the last word and I suppose we'll have the government say, "No, no, no," again and then have the vote.

**Mr O'Connor:** I appreciate where my colleagues are coming from on this. Mental health reform is certainly a very strong initiative of this government. It's something that we wish to proceed with and it's something that we're committed to. I think the importance here is that we try not to muddle the two.

Long-term care reform has got a definition to it; it's stated within the purpose clause. The importance here is that we're going to develop an integrated MSA and that we don't want to all of a sudden say that it has to provide mental health services now.

Frankly, talk about creating a huge bureaucracy: You would, if you were to go to as large a system as would be necessary to provide all the good services that are being provided today in mental health reform, in mental health services within our community today. When plans are developed for the consumer of—and maybe I'll ask for clarification on this—long-term care services, would not a referral take place to the appropriate mental health services within the community?

We will stand alone at our day, when the time comes and we have moved on long-term care reform. That's a standalone piece. The important thing here is that now we're dealing with the long-term care reform. What I'd like to know is whether or not there would be an appropriate referral where those mental health services are being provided today, because we're not envisioning the MSA providing all those mental health services as well.

If I could get some clarification through the honourable parliamentary assistant—

**Mr Wessenger:** I'll ask Mr Quirt to respond to that question.

**Mr Quirt:** Mr O'Connor is quite right that in developing a service plan for a client of the multiservice agency, it may well be the case that a referral would be necessary to a mental health professional, whether it be a psychiatrist, a psychologist or a counsellor at a community mental health program. It's not the intention of the MSA to directly employ psychiatrists, psychologists

and community mental health counsellors, but it certainly would be one of those services to which a client and the family would be referred if it was indicated that was necessary, and the actual mental health service might be provided from a facility or it might be provided from a community mental health program.

1150

**Mr Jim Wilson:** From what I've heard, then, there should be no problem with the amendment. It's just mind-boggling you couldn't accept the amendment. The only concern I've heard that has some legitimacy, I think, from the government's side is Mr Wessenger saying, "Oh, no, we don't want to put the words 'mental health' or 'mental' in this bill anywhere because we don't want to raise expectations that we actually care about the mental health of the population"—

**Mr O'Connor:** He never said that at all. Come on, now.

**Mr Jim Wilson:** —and that it's going to wait for airy-fairy phase 3 of long-term care reform. In the meantime, people are left out of the system, and the new system that you're creating.

What I would ask the parliamentary assistant then is, what is your definition of "health"? It's not defined in the definitions section of the bill; therefore, we need to know. If you won't accept this amendment, if nothing else, for the record I want you to tell us what the government's definition of "health" is. If you're going to ask us to support legislation that talks about promoting health, we'd better know what it is you're promoting, since you've said that mental health isn't necessarily part of health.

**Mr Wessenger:** No, no, that is not what was said. There's no question that "health and wellbeing" is very all-encompassing language and it includes the total aspects of all provisions, beyond even what the health service providers do. It's beyond that. It relates to all the determinants of health, which of course is a very broad concept.

I think it's fair to say that in every piece of legislation you could probably put a purpose clause to promote the health and wellbeing of persons, because that's what we're all about and trying to do in our society: to promote the health and wellbeing of all individuals in society. It's a very broad-based aspect and I will put on the record that yes, health does include the mental health of the individual, very much so.

The only concern is that if you read this, it says "to improve the quality of community services," and the community services are defined in such a way that they don't include mental health services. As I said, it's not a concern about the word "health." "Health" definitely does include mental health. I think generally in legislation you're better to use broad language rather than specific language. At least it's my preference to use all-encompassing, general language, as distinct from specific, as a lawyer, I'll say.

**Mr Jackson:** Spoken like a true lawyer.

**Mr Wessenger:** Yes.

**Mr Jim Wilson:** The last point I'll make on our

amendment then is that I hope that by rejecting the addition of "physical and mental health," by rejecting the language of this amendment, you're not precluding the acceptance of both the PC and Liberal amendments with respect to adding mental health to the community services that are to be provided by the MSA, because that's what I take is the signal, Mr Wessenger, and I'm very disturbed.

I think Ms O'Neill did an eloquent job of explaining also the necessity at this point to at least mention mental health in the legislation, because you're setting a very dangerous tone here and saying you're not going to accept any amendments later on today or this week with respect to mental health, and that is not acceptable.

**Mr Wessenger:** I think you're quite accurate in the sense that we will be not accepting amendments which will require mandatory professional services in the mental health area. That's quite clear.

**Mr Jim Wilson:** Well, that's just wonderful.

**Mrs O'Neill:** Okay. Could I then just have the parliamentary assistant's definition of the second part of that from the government's perspective? The "health and wellbeing": What does the government mean by "wellbeing"?

**Mr Wessenger:** The only thing I can say is that it's a very holistic approach, which obviously means it recognizes—and then if we just restrict it to long-term care community services, it obviously means that you look after services that will assist them in being—

**Interjection:** Well and healthy.

**Mr Wessenger:** Well, being healthy in all aspects.

**Mrs O'Neill:** "Let's not use the word 'mental' because it's too clear," I guess is what you're saying.

**Mr Wessenger:** It's wellness, really, promoting wellness. That's the best phrase you could say: We want to promote wellness.

**The Vice-Chair:** All in favour of the PC motion to amend clause 1(b)?

**Mr Jim Wilson:** Recorded vote.

**Ayes**

Jackson, McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Frankford, Johnson (Prince Edward-Lennox-South Hastings), Lessard, Marchese, O'Connor, Wessenger.

**The Vice-Chair:** The motion is lost.

Government motion 1(c).

**Mr Wessenger:** I move that clause 1(c) of the bill be struck out and the following substituted:

"(c) to recognize, in all aspects of the management and delivery of community services, the importance of a person's needs and preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors;"

This amendment clarifies the term "preferences," and preferences are to include those "based on ethnic, spiritual, linguistic, familial and cultural factors." This

responds to concerns presented at the hearings that the bill was not reflective of the concerns of ethnic, religious, language and cultural groups, so I want to make this very clear.

**Mr Jackson:** Could I have a clarification from the parliamentary assistant. Does that mean that persons requiring services will have the right to request support workers of the cultural or linguistic origin that they choose? Is that what is implicit here? I'd like to know.

The unions have indicated that they want that completely and absolutely eliminated in this province, that a recipient of care gets to participate in the choice of the care giver. It strikes me that this now sets out for the first time the promise that if I, for whatever cultural, linguistic or religious reason, would prefer someone else to provide that service—is that the promise we're holding or is this just more sort of puffery to help the bill along? I just would like to know.

I think that's its application for a service—you know, the minister keeps talking about empowerment and choices and everything. Can I reject a certain person now because I would prefer someone of my own religion who can help prepare my meals the way I want them and so on? What do you mean here?

**Mr Wessinger:** It relates more to the provision of service than it does really to the relation of who provides the service, and it doesn't really create a right. It's really a direction that you want to ensure that the services delivered are to the extent possible within the resources available to the service provider.

**Mr Jackson:** I'm trying to understand. You say that it's the difference between service delivery and a service deliverer, so what you're doing is you're taking the personalities completely out of it. So what are you saying, that it's sufficient for service providers to state that they're culturally sensitive and that's sufficient, but if they don't send someone into their home who's culturally sensitive, that's okay because they're a service provider and therefore the service provider's not required to be sensitive, but as long as the service is culturally sensitive?

Why are you not able to discuss the issue of what the unions told us, "We do not want any persons requesting services to be able to determine who gives them their services for cultural, linguistic and religious reasons"? That was reiterated by various organizations, but the unions said, "We will have no part of it." As a government you agreed with them during the public hearings and now all of a sudden we have this clause.

I'm trying to understand what this clause now means relative to the times it was raised in committee. You can give me your interpretation today and that may be helpful, but I thought the public hearings were to get this input. We had this clear conflict between where the labour unions involved have said they don't want the citizens to have rights and where the government at the time was saying, "We agree with you and we're looking at that and we'll have amendments." This is the amendments?

**Mr Wessinger:** I think it's fair to say there are

certain cultural groups that have certain concerns about how a service is delivered, for instance, even just the question of provision of meals. There are certainly dietary rules and regulations that have to be respected, certain religious aspects. The way personal care is delivered would certainly impact some way on certain cultural groups. In other words, the deliverer of service has to deliver the service in a way that respects the person's cultural and spiritual background.

I think that is what we're looking at trying to do. It's not a question of saying that everybody has to have someone of their own cultural background deliver the service, no, but that it has to be respectful of that person's preferences of how the service is delivered in accordance with their background.

1200

**Mr Jim Wilson:** I want to propose a compromise to the parliamentary assistant with respect to this amendment. I would support the amendment up to and including the word "preferences" so that the amendment would read, "to recognize, in all aspects of the management and delivery of community services, the importance of a person's needs and preferences."

The reason I would ask you to consider that is that I think you're being too narrow in attempting to be prescriptive by narrowing those preferences at this time; at least, it seems to suggest a narrowing to just the spiritual, linguistic, familial and cultural factors, although I do note—I'm correcting myself—that it says "including," which is what you're going to come back to.

**Mr Wessinger:** Yes, that's right.

**Mr Jim Wilson:** The reason I flagged that was that we attempt to deal with ethnic, spiritual, linguistic, familial and cultural factors in the bill of rights, but I want to make sure there that what you mean by "preferences" is that—I think the 80-20 rule in this legislation narrows people's choices and therefore, by definition, narrows their ability to express preferences and have those preferences adhered to or responded to by multi-service agencies.

I want to make sure, Mr Wessinger, that when someone, for example, who's currently receiving a Red Cross service in our ridings, if their preference is—because you're giving them here the right to state a preference in the delivery of community service—they can say, "Well, I'm quite happy with the service I'm getting, and I want my Red Cross nurse or my VON to come in."

If that's what you're saying here, then I'm very supportive of it and would hope that this is what you're saying and that you're contemplating getting rid of the 80-20 rule, which is arbitrary, monopolistic and problematic to the extreme in this legislation. That's why I worry that when you put the wording "including preferences based on ethnic, spiritual..." you are, in a backhanded way, trying to narrow what people can talk about in preferences.

**Mr Wessinger:** Could I just indicate that certainly you're quite right: The original provision, which just said, "to recognize the importance of a person's needs and preferences," would be interpreted to include the ones we

specifically added. But the words are added, and I don't think they detract from the general provision of needs and preferences. They were added to give comfort to groups who had concerns about the fact that we had not highlighted these provisions.

If you look back, I think in the long-term care facility bill we also put in some similar type of amendments to highlight preferences based on ethnic, spiritual, linguistic, familial and cultural factors. We had a lot of discussion, I remember, at that time. This really just parallels, I would suggest, what we did in the facility bill.

**Mr Jim Wilson:** It's an important clause because it ties into the rest of the bill, and I think the rest of the bill doesn't live up to this purpose clause here. If my preference is to continue to use a Para-Med nurse, a nurse provided by a private sector agency right now, this clause says I can state that preference and you have to respect it. That's a type of preference that may be stated.

**Mr Wessinger:** It should be pointed out that later on in the bill there is reference to the same language in the bill of rights, the multiservice governance sections and the plan of service. This ties in with what is already mentioned in three areas of the bill later on. So the language—we're putting basically purpose—

**Mr Jim Wilson:** No. I'm just trying to get at—I'm quite serious. Given that the bill is overly prescriptive, limits choice with respect to services and who will provide those services, what do you mean by the word "preferences" then, which is the key to this whole clause here? What type of preferences are left?

**Mr Wessinger:** This obviously relates to how the service is delivered to the individual in the sense of they have control. If there's a particular service they don't want, they can decline that, or if they want it in a way that—

**Mr Jackson:** You mean they get to decline it in Hebrew and then it fulfils this?

**Mr Wessinger:** No.

**Mr Jim Wilson:** No, no, no.

**Mr Jackson:** I mean, do they get the right to ask for it in Hebrew?

**Mr Jim Wilson:** Excuse me.

**Mr Wessinger:** No, no.

**Mr Jackson:** That's what I'm asking.

**Mr Jim Wilson:** No, I'm not getting into that right now.

**Mr Wessinger:** No, we're not getting into that. Mr Wilson is raising a different aspect. This section has nothing to do with the 80-20 rule, no.

**Mr Jim Wilson:** It does, in my opinion, because what are preferences? This says you have "to recognize, in all aspects of the management and delivery of community services, the importance of a person's needs and preferences...."

Now, if my preference is to tell you to go take a hike with respect to the 80-20 rule, or I live right next door to an agency that happens to be in another MSA area—I know we're dealing with cross-border MSA shopping later—I may have all kinds of preferences that are aside

from ethnic, spiritual, linguistic, familial and cultural.

I want to make sure your commitment is that you will respect all preferences, that you're not in some way trying to narrow it or say to people, "Yeah, you can express all preferences to us, but there's not a heck of a lot of choice left in the system because we're creating a monopoly, so you have no choice where you get the services or who delivers them."

I don't think you've thought of that with respect to this clause, and to me the word "preferences" says that in the management and delivery of services you are giving me the right now, as a potential client, to express a preference and you must try to meet that preference.

**Mr Wessinger:** Basically, the consumer's preferences are most relevant in establishing a plan of service because where they're going to be developed is in that area.

**Mr Jim Wilson:** I'm sorry, I missed that. What was that?

**Mr Wessinger:** The plan of service will be the most relevant to the consumer, and the question of recognizing their needs and preferences when they're developing the plan of service. That will be the key aspect, and revising that plan of service.

**Mrs Sullivan:** We will be supporting this amendment. We believe that in the purpose clause, by including the additional words, there's an underlining of a commitment to respecting the dignity of the human character of those people who are receiving services and that the inclusion of the words "in all aspects of the management and delivery of community services" means that the particular human needs of an individual are recognized, whether it's in intake, whether it's in an explanation or discussion of the plan of service, whether it's in the actual carrying out of the service, or even discussing changes to that plan of service.

We also think it should be recognized that by including these words in the purpose clause, a new right is not being conveyed, and that may well be difficult for the government to convey later on. But on the other hand, we made a demand during the course of Bill 101 that such cultural and religious factors be included as part of the premise for service delivery in Bill 101, be taken into account in the drafting of that bill, and we are pleased to see that the government is including it here. So we'll be supporting it.

As we're now just a little past 12 o'clock, I'm wondering if we shouldn't think about moving quickly on this one so that we can get into some afternoon things.

**The Vice-Chair:** Mr Jackson, did you have a further comment?

**Mr Jackson:** Just very briefly. I'm nervous about the references to what we did in Bill 101, because we're comparing apples to oranges. In Bill 101, for example, we protected St Joseph's Villa, which is a long-term care facility with an ethnic, cultural, religious catholicity. We protected them in the legislation. We didn't phase them out and we preserved their board. Under Bill 173 we're taking St Joseph's visiting homemakers and we're saying, "You have to compete for a small piece of the 80-20 market," which was my colleague Mr Wilson's concern.

In all likelihood, as we've heard from deputant after deputant, they will be wiped out.

When my senior citizen says, "I know some day I'm going to go into St Joseph's Villa and I have discussed it with my priest and my family and I accept that is the kind of environment I believe I deserve," they have had the right in Ontario to be served by St Joseph's visiting homemakers, and that's the service that's being wiped out.

When I said facetiously to the parliamentary assistant his only example of what the rights of my senior citizens in my riding are, and that's to reject treatment or reject service, then I used the facetious comment that they have the right in Hebrew to say, "I don't want that service." If that's what this clause means, then we're just putting words in a bill so that we can point to them, but in fact what they mean to the empowerment of individuals requesting services, whether it be so that their meals are respected, whether it's their language, whether it is their particular religious conviction and ethos and the environment in which they are provided those services, the Catholic agencies will no longer be providing those services with a mission statement. They will be hired by the government and therefore become government employees.

We only have to look at what happened to any references to religion in our schools to see what the heck is going to happen to any references to these agencies and how they are managed by the government. That's the point we're making, and we're not satisfied. But if all this is as the parliamentary assistant says, it's nothing to do with service delivery, it's only about service management. That makes sense for him, but I can't accept that this is what we're doing to this bill, because I think we could be doing more for people who've made these requests.

**Mr Jim Wilson:** It's a very good point raised by my colleague Mr Jackson in terms of if I as a Roman Catholic want services by St Joseph's visiting homemakers, St Elizabeth Visiting Nurses, that's my preference, and this clause gives me the right to state that preference, how are you going to provide me with those services when you wipe those nursing services out of business?

Simply put, this is a bunch of hot air on paper, Mr Wessinger. How are you going to, for example, live up to the spiritual needs of clients if those agencies don't exist any more? We know you're not going to allow crucifixes on the walls of the MSAs and that, because as Mr Jackson has already pointed out, all of that stuff, the Lord's Prayer and that, for the most part, has been wiped out of our public school system. MSAs will be a public system and they will be generic in nature and not spiritual.

Therefore, answer me, how will you satisfy my needs and my family's needs in a spiritual way when those outside agencies tell us they won't exist, because what's left over for them to provide does not provide the economies of scale or the critical mass to ensure that St Joseph's and St Elizabeth's etc, other members of the Catholic Health Association, can exist? We also have it in the Jewish community and many other communities.

Explain to me how in the world you're going to live up to the word "preferences" here with respect to a spiritual nature?

**The Vice-Chair:** Did you wish to respond?

**Mr Wessinger:** No.

**Mr Jim Wilson:** You have to respond. You're asking us to vote on this and it's a fundamental question. Otherwise it's a bunch of hot air on paper.

**Mr Jackson:** It's pretty clear the unions wrote the clause here.

**The Vice-Chair:** Mr Wessinger, do you wish to respond or not?

**Mr Wessinger:** No, I don't. It's rhetoric.

**The Vice-Chair:** Thank you. We're now ready for the vote. All of those in favour of the government motion to strike clause 1(c)?

**Mrs Sullivan:** Recorded vote.

**Ayes**

Frankford, Jackson, Johnson (Prince Edward-Lennox-South Hastings), Lessard, Marchese, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Sullivan, Wessinger, Wilson (Simcoe West).

**The Vice-Chair:** Carried unanimously.

The committee will adjourn until 2 pm this afternoon.

*The committee recessed from 1214 to 1412.*

**The Vice-Chair:** The social development committee will now proceed with clause-by-clause consideration of Bill 173. The next motion is a PC motion respecting clause 1(c).

**Mr Jim Wilson:** Just a clarification, Mr Chairman: The first 1(c) was defeated, is that correct, just prior to the break?

**Mr Wessinger:** It passed.

**The Vice-Chair:** Yes, unanimously.

**Mr Jim Wilson:** Oh, that's right. Sorry. I ended up supporting it because we had no choice. We made our arguments.

I should say before moving our 1(c) that part of the voting here, I hope the viewing audience understands, is that we have a different vision of what an MSA should look like. What we try to do is put forward our vision, which is a federated model. When in those sections leading up to our federated model our amendments are defeated, we are then left with having to vote on government motions and we have to, for the good of the province, try and do the best we can to amend the government motions and vote on those. I think that's true of all opposition members. You've got to give it your best try with your vision, and then you're stuck with the government vision, which has a majority on this committee and in the Legislature.

I move that clause 1(c) be struck out and the following substituted:

"(c) to ensure that the paramount objective is to promote the best interests and wellbeing of the client, ensuring that a person's needs and preferences in all aspects of the management and delivery of services are met."

This particular amendment was suggested to us by the Ontario Community Support Association; a number of its branches brought forward this amendment. It's again an attempt to ensure that this bill actually accomplishes what it was set out to do, what has been sold to the public.

When we talk about "the client" in this amendment, I want to make sure—because in no other place in the bill could I figure out how children's services should be put in the bill. While this particular amendment doesn't specifically speak to children, it does give us the opportunity to talk about clients. I think Mrs Sullivan correctly indicated earlier today that this bill is to serve children, seniors and the disabled, yet we don't delineate that anywhere in the bill. So here we say, "the paramount objective is to promote the best interests and wellbeing of the client," the client being children, seniors and disabled.

I wanted to ask the parliamentary assistant a question in the form of reading a statement from the Association of Treatment Centres of Ontario in a letter to me dated October 11, 1994, by Valerie Elliott Hyman, who is the chief executive officer of the association. In part, the letter reads:

"We are supportive of the principles underlying long-term care reform, and uphold the principles of accessibility, affordability and local planning. We are requesting an amendment that will state that services for children will be planned and delivered within the existing children's system by those specializing in children's services.

"We are not asking for structural changes, we are asking that the bill states a principle so that attention will be paid to the special needs of children in the planning at the local level, that the needs of children will not be lost in a system primarily designed to meet adult needs, and that needless duplication of services will be avoided."

In part, that's what the letter says. It also indicates that their position is supported by the Easter Seal Society and the Metropolitan Toronto Association for Community Living. As a question to the parliamentary assistant, how are "clients" in this case—I wanted to take this opportunity to work in children. How are children's services addressed in this act?

**Mr Wessenger:** This act does not distinguish in terms of recipients with respect to long-term care. All persons who have need of long-term care, including children, have the right to those services. It was felt that it would be the wrong approach to try to set out target groups such as seniors or the disabled, to specifically describe them in the bill. It's clearly set out that it provides for—I mean, we've recognized "a person." "A person" includes a child.

**Mr Jim Wilson:** With respect to the role of multiservice agencies and children, though, and in particular the treatment centres throughout the province, just for the record, how do treatment centres delivering services now to children—and there is a number of them, ranging from Belleville to Windsor—fit into the multiservice agency model?

**Mr Wessenger:** I'll ask Mr Quirt to specifically set out how children's treatment centres deliver services. As a general introduction, I think it's clear that children's

treatment centres will continue to deliver many services as a separate program. Also, there's a provision, of course, that MSAs will be able to purchase services from, for instance, children's treatment centres. I'll ask Mr Quirt to fill out the details.

**Mr Quirt:** Children's treatment centres currently receive their funding from three sources. They receive funding usually from the Ministry of Education, and they receive direct funding from the long-term care division. That direct funding will continue and won't be affected specifically by the formation of multiservice agencies.

The third way they receive funding is when, currently, the home care program chooses to purchase therapy services from a CTC when they're delivering support services to children at home or discharging their responsibility for the school health support program. That's probably the smallest portion of the funding CTCs currently get. But given that home care programs often choose, if there's one available, to buy their school health support services from children's treatment centres, we suspect MSAs would probably continue to do that in most cases. In other words, when trying to deliver therapy services to children at home or in school, they will most likely call upon CTCs, like the home care program does now, because of the particular expertise and experience the CTCs have in serving children.

1420

**Mr Jim Wilson:** What effect does the 80-20 rule in this bill have on purchasing services through the MSA? You mentioned the other sources of funding for children's treatment centres, but how does the 80-20 rule affect that?

**Mr Quirt:** The multiservice agency in deciding to purchase professional services, therapy services, from a CTC would be using a portion of the 20% it's allowed to use for purchasing in that professional services category. In other words, the services bought by the MSA from the CTC would come out of the 20%.

**Mr Jim Wilson:** I think there's going to be a tremendous amount of pressure on that little bit of approved budget the MSAs are able to use, the 20% they're able to use for outside agencies. What if the case is that we find throughout the province that the 20% is used up on other priorities and not on those services to be purchased from children's treatment centres? What happens then? Is there any flexibility in the act if an MSA runs out of its 20% allocation and no longer has any money but also needs children's services from the local children's treatment centre? In that scenario, how would the MSA purchase services?

**Mr Quirt:** First of all, the value of the services currently purchased from CTCs for the school health support program would be far, far less than the amount purchased from other service providers by the home care program, so it's not a major amount of service we're talking about here. But in the scenario you've described, which is theoretically possible, that in a particular community the demand for children's services was such that the MSA encountered a problem in meeting that demand within its 20% limit, then that would be a signal to us as a ministry to take a look at the core funding of

the children's treatment centre and see what other programs and services need to be established.

The primary relationship we have with them financially is a direct contractual arrangement, a direct funding arrangement. If the services were that much in demand that it was putting a strain on the 20% rule, the CTC would no doubt be telling us it needs more in its base budget to meet the demand that exists locally.

**Mr O'Connor:** Further on that line of questioning—and I appreciate that my colleague wants to put in something respecting children—there would be no change in the way children's services through children's treatment centres are being provided today, is my understanding, that they are standalone centres and would continue to operate as they do today.

**Mr Quirt:** That's correct. They'd continue to be funded directly and to be standalone centres as they operate today. Clearly, the multiservice agencies will be responsible for delivering the same level of support to children whether those children are clients of the MSA at home or clients of the MSA in the school health support service program. In fact, we hope allowing a more flexible approach to packaging services will result in children being served better, as opposed to not as well.

**Mr Jim Wilson:** One final question, not to belabour the vote on this motion: Could a CTC become an MSA specifically for children if that were required in a geographic area?

**Mr Quirt:** There's nothing in the bill that would preclude that, but in order for that to happen, obviously a lot of discussion would have to take place at the local community and the district health council would have to recommend to the minister that that was the best approach.

Questions about fragmentation in service for children versus adults and families versus children would have to be addressed in that planning process. But the strict answer to your question is no, there's nothing to stop a DHC from recommending a children-specific MSA, and nothing in the bill that precludes the minister from approving one.

**The Vice-Chair:** All in favour of the PC motion regarding clause 1(c)? Opposed? The motion's lost.

Government motion re clause 1(c.1).

**Mr Wessinger:** I move that section 1 of the bill be amended by adding the following clause:

"(c.1) to integrate community services that are health services with community services that are social services in order to facilitate the provision of a continuum of care and support."

This additional purpose responds to concerns raised in the hearings that Bill 173 was not reflective of one of the major principles of long-term care reform, that being the integration of health and social services.

**Mrs Sullivan:** We'll be supporting this amendment. We think it strikes to the heart of the bringing together of health and community services in a long-term care environment and feel it's an important amendment particularly because it speaks to the continuum. In our next amendment we have brought back the word "con-

tinuum," which is now in clause (d), and I'm glad to see it included in this section.

**The Vice-Chair:** All in favour of the government's motion? Opposed? Carried.

A Liberal motion re clause 1(d).

**Mrs Sullivan:** I move that clause 1(d) be struck out and the following substituted:

"(d) to simplify access to a continuum of community services and to improve the coordination of community services by providing a framework for the development of multiservice agencies."

You will notice that the changes included in our amendment are simple ones. The first is the addition of the word "access" following "simplify," so that it reads "to simplify access," which is certainly one of the issues that, people have indicated, through the years has been one of the more difficult issues associated with finding long-term care and ensuring that one qualifies for it and so on. We also believe the coordination improvement is very important, so we've taken the improvement of the coordination of community services as something that ought to be emphasized. I'm asking for support for this amendment.

**Mr Jim Wilson:** In comparing the Liberal amendment with the bill as written, I'm wondering if Mrs Sullivan wants to give us a stronger case for supporting the Liberal motion, because as written in the bill, with the exception of the word "coordination"—I guess I'm not convinced there's a need to change the wording of the bill. Perhaps she wants to try again.

**Mrs Sullivan:** I think it's important to understand that access is only one part of the issue here. The simplification of access and the coordination of services go hand in hand in ensuring that people receive care that's appropriate to their needs. We feel that while the amendment is simple, it ought to be considered.

**Mr Jackson:** I think it's a very cleverly worded amendment, one which I'd like to support, because it talks about improving the coordination of community services within the MSA framework. Frankly, the biggest knock we're hearing about it is that the MSA is a controlling body and not a coordinating body. I like this amendment because it leaves it open within legislation that won't have to be amended in four or five months when there's a new government if it wants to change slightly the direction of the MSA model. I think we can now look to the purposes section to see that an MSA may not be as all-powerful, with an 80% rule, with this phrase in there; therefore I'm most pleased to support it.

1430

**Mr Jim Wilson:** I understand and I do support, now that I've had it explained to me, the need for "coordination" added. The problem with this, though, is if you compare this with the PC motion to follow, we're trying to say that the model of the MSAs as proposed in the government's legislation is not a good model. We would like to go to federated multiservice boards, much along that envisioned by the VON and the Red Cross, which would allow these agencies to stay in existence and get rid of the 80-20 rule.

I need your guidance. If I were to support Ms Sullivan's motion right now, and given the extreme hypothetical possibility that the government might actually support one of these opposition amendments, I just wonder how I could work my motion in, which is supporting somewhat—and we could add the word “coordination” to the PC motion, but it goes further and introduces a new model of MSA. I'm worried about the Liberal motion in that it just perpetuates the status quo as written in the bill with respect to MSAs. Maybe Ms Sullivan later on tries to tackle the MSA, but this is one of the first mentions of MSA in the purpose clause, and I need to tackle our new model up front. Is there any guidance there from the impartial Chair?

**The Vice-Chair:** Ms Sullivan indicated she'd speak to it before I—

**Ms Sullivan:** My sense is that this particular amendment would not in fact change or affect the Conservative amendment which is to follow. There is no word “coordination” anywhere in the purpose clause of this bill. The coordination aspect of services, whether they are provided by the MSA, whether they're purchased outside, whether it's coordination of health and other social services that are provided through another organization, including adult day programs and so on, must be acknowledged.

The coordination factor is a key, key factor in ensuring that the whole process of access to service is made more convenient and more timely for the person who requires those services. I believe the word “coordination” ought to be included, and once again I urge the government to accept this amendment.

**Mr Wessinger:** We will not be supporting this amendment for two reasons. First, I think we lose a great deal by deleting the words “and improve access,” because the intention is not only to simplify access but also to improve access. The other aspect is that the purpose contemplates the development of a brokerage model of service delivery and we're looking for the direct service delivery, so for that reason we're not supporting it.

**Mr O'Connor:** I appreciate the opportunity to comment on this Liberal motion. I think it's unfortunate that my honourable critic has removed the part that says improving access. She's talked about the continuum of care, and I know that she sees in this a coordinated response or a brokerage model or something else is where she's been advocating, in the direction she's been advocating, and we'll hear more of that. Given that, I unfortunately won't be able to support this motion as it has been placed before us.

**Ms Sullivan:** I want to make it very clear that we do not support only a service coordination model, that we do not support a sole access and delivery model, nor do we support only a federated model. We believe, given the rules and guidelines that are established by the government and the standards which have to be accommodated under the law and under the regulations that have to be met, the agency which provides those services ought to be designed in a manner that suits the needs of the community. Therefore, we believe that there should be flexibility in the bill.

In fact, I will not be supporting the Tory motion which is to follow that says there should only be one different kind of model. I don't think the government's model is right and I don't think the Tories' model is right.

**Mr Jim Wilson:** You don't know our model yet.

**Ms Sullivan:** I believe the models for delivery ought to be determined to meet the needs in each community, with representative boards ensuring that the delivery mechanisms are appropriate for the community. What will work in Renfrew county will not work in beautiful downtown Toronto.

I want you to understand the coordination is very much a part of our view of what long-term care reform includes and should include. But secondly, I also believe that even in the government's inflexible model of delivery, coordination of services is still going to be a major and vital part of that model, because health care services which are not provided within the MSA will have to be coordinated. Specialized services, including those for children, including those for people with other disabilities, will have to be coordinated. The entire issue of the self-funding of attendant care will have to be coordinated.

The word “coordinated” appears nowhere else in this purpose clause, and I think it's absolutely vital that this role—and it's a very simple word. If the government wishes, I will amend my proposed amendment to take the wording back to the original, “to simplify and improve access to a continuum of community services and to improve the coordination of community services....”

There is going to be more required in community services, and we have just adopted a government amendment saying that this bill is to bring health and social services together. That coordination is a vital part of long-term care reform.

Once again, I will propose an amendment to my amendment, Mr Chairman, by moving that—

**Mr Jackson:** You can't amend within a motion.

**Mrs Sullivan:** Yes, I can.

**Mr Jackson:** You can?

**Mrs Sullivan:** Certainly I can.

**The Vice-Chair:** It's an amendment to the Liberal motion.

**Mrs Sullivan:** That's right. An amendment to the Liberal motion.

**The Vice-Chair:** Ms Sullivan is proposing to amend her Liberal motion.

**Mrs Sullivan:** That the words “and improve” be added before the word “access” in the first line.

**Mr Jim Wilson:** I'm prepared to support the new and improved Liberal motion, but I think there's been a misunderstanding by Ms Sullivan in terms of she doesn't understand—and it's not her fault, because I haven't had a chance to explain—what our federated model is, which gives maximum flexibility to communities. I agree with her comments about that and that this bill is overly prescriptive, and we would not want to do anything to make it more prescriptive where that doesn't make sense. So I would call the vote on the Liberal motion.

**The Vice-Chair:** Did you wish to comment?

**Mr Wessenger:** No, I have no questions.

**The Vice-Chair:** We will first vote on the amendment to the Liberal motion, which was to add the words "and improve" between "simplify" and "access."

All in favour of the amendment to the Liberal motion at this time? Opposed to the amendment? The amendment is lost.

I put the Liberal motion at this time. All in favour of the Liberal motion regarding clause 1(d)? Opposed? The motion is lost.

PC motion regarding clause 1(d).

**Mr Jim Wilson:** If I may, Mr Chairman, given the discussion we just had, I would like to make this an additional clause as (d.1). I move that clause 1(d.1)—or how does that work? I move that section 1 of the bill be amended by adding the following clause:

"(d.1) to simplify and improve access to a continuum of community services by providing a framework for the development of federated multiservice boards that shall make available and operate a telephone service which will enable a person to access information on all community services available in the community in which the person resides by dialling a single number."

1440

This is the beginning of a series of amendments that attempts to change, alter, the monopolistic and bureaucratic nature of the government's proposed multiservice agencies. A federated multiservice board, as we are now calling it, was put forward by a number of groups, particularly the Victorian Order of Nurses, the VON, which said, "We should have a federated board that includes persons appointed to the board by the health and social services agencies who are partners with the community in the multiservice agency."

We've altered that slightly to say, and our vision of a federated multiservice board is: "Government, don't tear down the existing delivery structures. Simply go back to the communities and set a time frame; say, 'You've got one year to get back to us and meet the objectives of this legislation or the purpose of this legislation.'" The existing players in the system now, the service provider agencies in a given geographical area, will each appoint one member to a federated board and the government—you'll see later amendments—will appoint some consumers to that board.

Together, much like a federated board at the University of Toronto, for example, where nine universities come together and make governing decisions through an umbrella board structure—we have many, many institutions that operate this way. It's a federated model that allows individual players to have a say in the overall coordination of the system.

We later take that model and say there has to be a common assessment tool that they're to come up with in their local community and change the bill. In fact, you don't really even need the legislation other than to set out purposes of what you expect these federated boards to accomplish in a set period of time.

We say to communities: "Government isn't going to dictate to you what the multiservice agency has to

specifically look like in your area. The rules are, you take a player from each of the existing service agencies, create a federated board, no new administrative dollars for your area"—you'll see an amendment a little later on, saying that each of the existing service provider agencies has to pay a fee towards the new board structure—"and give them a time frame to come back to government and say, 'This is how we're going to provide.'"

Specifically, in this motion we talk about the fact that one of the things that's missing in the bill is a common phone number, which doesn't even exist, which is what you heard when we talked to those 75,000 people. They wanted a common phone number, a common point of access.

So we allow a federated board. We don't tear down the existing service providers, because we happen to think they're doing a good job in a cost-effective way.

Given that there is no cost-benefit analysis or no study from the government to prove to us that VON and Red Cross and Saint Elizabeth, Para-Med, the private providers, all of those other players in the system now are overly expensive, but given that the true purpose of this phase of long-term care was to coordinate these services, provide one point of access, one phone number for a geographical area, why don't we go with the federated board model that allows them that flexibility and say, "Look, we're going to take out the rest of the prescriptive junk in this bill and simply tell you, each area, through your district health councils, to come back to us and tell us how you're going to overcome and respond to the needs of one phone number for the area, a coordinated and common assessment tool and coordinated services, in eliminating duplication in your area if it exists now"?

That's what we mean by a federated agency. It has been proposed by a number of groups, which I would like to put on record if I can get all the short forms down. The Algoma Health Unit was one that talked about it. They proposed a federated model involving the collaboration of existing agencies, with an emphasis on improved coordination. This could avoid the costs and problems of amalgamation.

The VON, various branches, spoke to us about the need for this. I just quoted from VON (Ontario). Specifically, I would like to quote from the Victorian Order of Nurses, Thunder Bay and District Branch, which said, "Accept flexible models, stressing partnerships among agencies rather than devouring agencies, their staff and volunteers."

Again—just bear with me, members—the Coalition of Community Health and Social Service Agencies of Hamilton-Wentworth recommended to us a model based on a federation of agencies under an umbrella organization with consumer and citizen participation on the board of directors rather than an amalgamation model.

The Ontario Hospital Association recommended abandoning the highly structured MSA approach that's contained in the government's bill and adopting a federated model, which includes hospitals, to build on existing community resources. Our model would not preclude other players, like hospitals or existing service providers, in a geographical area.

I have just a couple more. The Providence Continuing Care Centre, which is a member of the Catholic Health Association of Ontario, recommended that multiple providers, which retain their individual identity and mission, function under an MSA umbrella organization to offer consumers freedom of choice in available services. They went on to talk about essentially a federated model. There were many, many other organizations that recommended this approach to us.

If you really think of it, government, you don't need to be overly prescriptive. If the true agenda here is to provide coordinated services, one phone number and a common assessment tool, which I think were the big three—members may want to add more, but those were the big three points that needed to be addressed in this phase of long-term care—then why wouldn't you allow a federated board, much like our universities run, and many other organizations run that way, and you don't tear down the unique identity, function and mission of the current service providers in any given area?

That's what this motion attempts to do in the purpose section. It also talks, as I said, for the first time about a phone number, which I think should be something that this bill sets out as an absolute must for given areas. I would ask members to support it and I would welcome their comments, because it is a federated model and the government so far has rejected it, but I think common sense dictates that this is the way we should be going, and not with the bureaucratic, monopolistic MSA model as proposed by the government.

**Mr O'Connor:** I appreciate the arguments as put forward by my friend Mr Wilson. It's interesting that he compares the federated model, as he envisions it, to the accountability of a university board. I know that when the public accounts committee took a look at accountability on university boards, I don't recall that same comfort of accountability. In fact there was an awful lot of work that continued on around that. I don't think what he sees envisioned here has the same type of accountability either.

It would seem to me that there would be conflicting roles within a board as made up through this federated version that he sees, where you have many different service providers perhaps at some point even trying to compete among themselves. It doesn't seem to take away, then, the administrative overlap. I know he doesn't believe, for example, the numbers that the Price Waterhouse study had said of 30%, and that's fair, but still there would be administrative overlap that I don't think is being looked at.

The role of the consumer, which we believe is very important in this—in fact we'll have amendments to address that later on. But the local accountability, again, where does this tie into the local accountability which he has pointed to by having different boards? I know that there were some difficulties presented to us by the Red Cross in sitting in this type of a situation. They said that they would have some difficulty with it.

1450

There are a number of things that I think have to be looked at. I appreciate that he's suggesting, for example,

the one phone number access to it. I wouldn't even want to say that this is the correct approach, because the province itself is quite diverse. You take a region as large as Durham region. Their access point could be different and there could be a couple of different phone numbers in there. I mean, talk about prescriptiveness. It would be hard for us to put in legislation that it's going to be one phone number and then say that this isn't going to be problematic in itself. That would actually be a little bit more prescriptive.

I appreciate where he's coming from on this and I realize that he's got his viewpoint on this. A lot of questions that I have have been left unanswered, but I appreciate the thought that he's put into this as a model. At some points we do disagree; this is one of them. I won't be advising my colleagues to support this motion as presented to us.

**Mr Jim Wilson:** Could I just clear up a couple of points real quick? One is, I don't think the Red Cross would have a problem, because I'm not talking about an incorporated board here; I'm talking about just partnership, which, believe it or not, is already happening in the province. Throughout this province, groups have got the message about Bill 101, that they have to coordinate services and that. By themselves, with no new administrative dollars, they're meeting several nights a week, informally, coming together in coalitions, in a partnership model, without Big Brother telling them how to do it or holding a gun to their head. They are coordinating services without the government's help right now.

Prior to that even, it's a fallacy to think that the seven major players in—again, I go back to the one I know best—Simcoe county, prior to any government involvement in this legislation didn't talk to each other and coordinate services anyway. They did. They meet each other at the grocery store, at the hardware store. They refer clients to each other; they share client information now.

What we're saying is, if you want to meet the true objectives of this phase of long-term care, don't be overly prescriptive; don't pass legislation that, by the way, you're going to have a dickens of a time dealing with in the future in enforcement and all that sort of thing, and let them come together in a partnership federated model.

The Red Cross fits into that model if we drop the incorporation section, if we say that they don't have to be a co-op and they don't have to be a non-profit organization; they don't have to be anything. It's just a partnership model that government sets out the broad strokes of and allows communities to set and coordinate services and tell government, for a change, what's needed in Simcoe county, what's needed in North Bay, what's needed in Thunder Bay, what's needed in London, Ontario. The Red Cross could participate in this model if you'd make some other changes to the act which are quite simple.

Local accountability is the other point he raised. It is there in terms of, we will have consumers on this, plus it has as much local accountability as your non-profit MSA organization or your co-op in terms of, if you follow the reasoning of your own legislation right now, the

accountability is eventually in the hands of Parliament and parliamentarians anyway.

You have such a prescriptive bill on the table now that you don't even trust local communities, because your bill clearly says that at the end of the day the minister can do whatever she wants with these MSAs. She can approve them, not approve them, revoke their approval. At the end of the day you don't, in your own bill, trust communities, even though you've used all the politically correct language to put consumers and non-profit and co-op boards together. At the end of the day you don't trust them to do it.

First of all, in your bill you tell them everything that has to be done, so I don't know what they're going to meet for, except to say, "Jeez, Joe, how are we doing with the government's bidding today?" "Well, I guess we're getting through doing what the government wanted us to do." There's not a lot of community flexibility in your bill.

Secondly, by your own writing of legislation, accountability ends up back in the minister's lap because she or he holds all of the strings in your own legislation. Our bill frees that up and says that communities are truly to work with each other in a partnership through the DHC and tell government what's good for the local community, not the other way around.

**Mr Wessenger:** I can't support this motion because, first of all, it prescribes the framework for the development of a federated multiservice board, and that's certainly not the model this legislation contemplates. Secondly, I do have some concerns about specifically setting out the method of access by telephone service, because I personally think access has to involve human contact with respect to providing services. Telephone access certainly may be a major problem with respect to those persons who are deaf or suffering from a hearing impairment or those perhaps having a literacy problem.

**Mrs Sullivan:** Once again, we won't be supporting this amendment because I'm concerned that by itself it creates a new kind of inflexibility with respect to the design of the model that may be useful in some areas of the province but, again, not in others. We believe very strongly that a multiservice agency or a central agency in each community ought to be clearly responsible for the intake, the provision of information, in whatever way that's done, perhaps through a telephone system, but surely we don't need to put into a legal surround the fact that an agency would operate a telephone system. Assessment also would be very much a part of what that central agency should do.

Where there is a major division, I suppose, in thinking and philosophy is with respect to the government's determination to legislate one model for delivery of services. In our view, that is an egregious error. The government's model may well work, as I've indicated, in some parts of the province, and those people who are involved in the issue surrounding long-term care, including providers and consumers and other people in the community who have been dealing with these issues over a period of time, may well believe that is the appropriate way for that community to proceed. In other areas,

however, it is the wrong way to proceed. I guarantee that this long-term care model that the government is putting forward in this bill will not work in Renfrew county. The culture of Renfrew county and the history and the experience of the way its services are operated and have been coordinated on a cooperative basis require and need a very different approach to what the MSA will do.

The government's 80-20 rule—and I suppose we have to talk about that while we're discussing this particular amendment—is one that severely limits a community's ability to decide what will work best with the resources that are available elsewhere in the community and the most efficient and effective way of ensuring that people do have improved access and increased coordination of services and the kind of quality of care they need. I believe that in its own way this amendment is itself inflexible, and we'll be voting against it.

**Mr Jackson:** I'm surprised to hear Ms Sullivan argue all the way around the room on this one. It's a given that there should be flexibility in this model. I was with her on that. I was with Elinor Caplan when she first set out the federated model as a vision and I was with Frances Linkin when she set out a federated model. So that's where I thought we were going with long-term care, and I have to say that when Elinor Caplan and Frances Linkin were at the helm, we had the largest degree of consensus in the province of Ontario about long-term care reform, no question. Where we got into trouble is around this major component of this bill, which is around the federated model.

Now, maybe our wording isn't exactly acceptable to Ms Sullivan. We understand the government is going to stonewall the notion of having flexibility and it is wedded to the brokerage model, but I just can't understand why the first reference to the potential for flexibility for a federated model is being dismissed outright by the Liberals.

What concerns me is that when this legislation comes into play, when it's proclaimed and then we have a three-year window of development, it's important that we give a signal to those communities that wish to at least apply to the minister with a model that is formulated along these lines.

**1500**

I'll just give you an example. Regardless of the fact that my colleague has given us a full list of groups coming forward asking for the federated model, I'm here to report from my own region of Halton, where our groups came together under the minister's direction to get on with the planning for an MSA, that in Halton the consensus was to ask for a federated model. The chair of the social services committee for our region, a well-known socialist, alderman Bob Wood, who chairs the committee, an NDP-card-carrying member, said: "Absolutely no way. We're not even interested in listening to a federated model. So don't even ask for it." Well, they asked for it and they were told no.

There may be other areas of the province that say: "Fine, we'll take the brokerage model. Bring in the civil servants. Rent more office space. Buy a bunch of equipment. Go for it." But in those communities that are

looking for a federated model, we should at least be setting out some opportunity in legislation that they can approach it on that flexible basis. I, for one, participated in the two days of hearings and invested my time as a legislator in the model that's being developed for Halton and listened to a lot of groups that were appealing for that, but I had this one alderman who chairs the committee saying: "Nope. That's our marching orders. We're not prepared to look at that."

I want to move to the issue of this telephone number, which the government itself was indicating as a big issue throughout the public hearings, and now, at the first opportunity to make any reference to single-point access, we can't find a way of putting it. We're open to any suggestions, but when Durham region comes forward, as did York region, to say, "Look, we're putting in our 1-800 number and it's working"—Mr O'Connor, I'm a bit confused about the position you're taking when in fact that's exactly what groups that are trying to build these coalitions are doing and what the MSA will ultimately do. Of course, the bill goes on to say there'll be access for other groups. So for the parliamentary assistant to suggest that there isn't some form of a one-window or one-point access for a senior citizen—I thought that was the major thrust of this bill. I'm not seeing it.

I know that when my colleague, with the support of Mrs Sullivan, indicated we wanted mental health services covered, the NDP's response was, "We don't want to muddy the waters," and the parliamentary assistant said, "We don't want to raise expectations, so we should have a separate and second phone line for them." Maybe you want a third phone line for children and maybe you want a fourth line for Down syndrome families. That's your business, but what we're saying is that there should be a single point of access somewhere in this bill, and this is our first opportunity to make reference of it.

That's all that we were seeking in this section. If there's any will on the part of the government or the Liberal Party to work cooperatively with the suggestion that we be flexible enough for a federated model, here's where you start putting it in. If you don't, then you've set the tone for the rest of the bill, and there's no sense in wasting a lot of legal staffs' time drafting amendments that are structured around a flexible model, because they have to be told early in the bill—we're looking at 100-some-odd clauses to do. We have to amend every single one of them and that's why we felt it's important that we serve notice early that this bill should have that flexibility in it.

But I am distressed in the extreme to hear that the Liberal Party, under no form or shape, will be supporting any reference to a federated model in this bill. That is quite extraordinary, from my point of view. I thought that was the position of Elinor Caplan, I know it was Frances Lankin's view until she was removed from the ministry, and we know it is not Bob Rae's, and Ruth Grier, the current minister's, vision for Ontario. But at least it was Frances Lankin's and Elinor Caplan's and it still remains, to this day, the vision for the Conservative Party of Ontario.

**Mr Jim Wilson:** I just want to note that this idea was

also floated by the minister herself in a letter to the Metro district health council dated May 13, 1994, when she referred to suggestions about interim MSAs:

"An interim or transitional strategy may be a federation of long-term care agencies agreeing to work together to provide services for a particular area." She goes on to say, "The federation would include hospitals too, to allow for a continuum of care and enhanced flexibility for local decisions about using the best agency for the job."

That was the government's position and advice to the Metro DHC when it was discussing interim multiservice agencies. I guess my question is, if a federated model, a partnership model of existing service providers in a given area, was okay back in May, what happened on the road to today? Well, I think you'll hear throughout these clause-by-clause hearings a number of theories of what happened, and one of them is one-stop unionization and we'll talk about that eventually.

But I want to, in defence of our model, just set out the parameters of the model that were presented to this committee on September 13, 1994, by VON Ontario. Fay Booker, who is president of VON Ontario, and Gale Murray, the provincial executive director of VON Ontario, among others, presented to this committee.

The VON's desired model for the MSA for the most part is a partnership model, as they outline on page 5 of their brief. In that model, they say it will have the following ingredients: It will be "accountable, efficient and effective governance through a federated board bringing together consumers, community representatives and providers." All of that is available in our amendments.

The next point they make about their federated model is "accountability to the community through election locally of the directors and with the majority being consumers." Now, that is not in the PC amendments. For the record, we didn't feel it was necessary at this time to elect MSAs locally, because we wanted to have a true partnership between existing service providers and consumers, and we don't want more government. We can go into that, but for a lot of good reasons in this province I think we're already over-governed and the people of this province don't want another layer of government and that's one of the reasons they're rejecting MSAs.

The next point the VON made in their model, though, which we did accept and is incorporated for the most part in the PC amendments, beginning with this amendment, and that's why it's so important, is "an integrated service featuring: one-stop access by telephone or in person." Just because we mention the telephone in the bill doesn't mean people can't walk into the office too. It's ridiculous to think they can't. Not only walk into the office, but also have assessors go out to their homes. There's nothing to prevent common sense from prevailing. Especially if we don't legislate this too prescriptively, then local communities will decide how to best meet these needs.

"Referral of clients to the appropriate service and provider." Now, I know everyone says that's the brokerage model and they're rejecting it, but we did not hear a great deal about what is wrong with the brokerage model. As I said, if you're prepared to give me evidence that the

VON is broken and needs to be fixed or the Red Cross home care is broken and needs to be fixed, then I'm prepared as a legislator, on behalf of the people we represent, to help you fix it. But you've not given us overwhelming evidence that things need to be fixed. In fact, the volunteers who work for those agencies, the 10,000 who volunteer for Red Cross alone, many of them have come forward, not only to the committee but in meetings we've had outside of the committee as MPPs, and told us that things aren't broken, that one of the reasons they volunteer for these agencies is they think those agencies deliver damned good service now to the community and you shouldn't be tearing them down.

1510

Another component of the VON model under integrated service features was "comprehensive service availability." Well, we talk about that in other amendments. "Multidisciplinary/geographically and specialty teams." In some of the government's own stuff, that's already provided for in the bill.

They go on to say, "The effectiveness of this partnership model can be ensured by: automated information system using standard datasets to allow comparability."

A proper data information system and sharing of that information is necessary in this system, and we intend to do that through smart card technology with our health card system, not invent a new system for long-term care. We have massive agreement from all of the players that that is what's needed ultimately for the health care system, and it will be done in a short period of time if we form the government.

"Staff 'on line,' i.e. utilizing computers to avoid repetitive data collection and allowing for state-of-the-art clinical practice and better coordination of services." Again, you don't need an amendment to deal with that.

They go on to talk about "a common client record system."

You need perhaps another piece of legislation to deal with smart card technology or smart information technology, which both opposition parties talk about, but that's another bill to deal with the data system.

**Mrs Sullivan:** So you heard my speech.

**Mr Jim Wilson:** Oh, baloney. Don't even get me started on your failed health card system, Ms Sullivan.

But anyway, the government totally rejects this model, and I'm going to give the parliamentary assistant an opportunity to tell me why. Why do you want to get rid of these existing agencies that for the most part are providing services through volunteers and in a cost-effective way? Give me a good reason, because you've just not sold us on it to date.

**Mr Wessenger:** It's really not relevant to this provision or this clause. However, I think I've indicated earlier that I believe that the direct—

**Mr Jim Wilson:** It is relevant, excuse me, because I'm trying to prevent you from putting the existing service providers out of business, and this is the first opportunity—

**Mr Wessenger:** Oh, yes, I agree, that's what you're—

**Mr Jim Wilson:** —to make sure you don't make this fatal error, Mr Wessenger, which I'm sure you'll be around for a few more months to regret.

**Mr Wessenger:** I think it's very clear that it's believed that the best model of delivery is a functional, integrated service delivery model, and that's the best way to meet the needs of consumers in an efficient and effective method. If we look at subsequent amendments, we want to provide for the efficient and effective management of the human, financial and other resources involved in the delivery of community services. That's the whole purpose of the legislation and that's the purpose of what we're trying to do with respect to the development of the MSA.

**Mrs Sullivan:** I want to make it very clear, particularly to Mr Jackson, who doesn't seem to understand, that we are opposing—

**Mr Jackson:** You should have been at the meeting in Halton, and then you'd have understood it.

**The Vice-Chair:** Ms Sullivan—

**Mrs Sullivan:** I know precisely what happened at the meeting in Halton, and I know precisely what happened after the meeting in Halton—

*Interjections.*

**The Vice-Chair:** Ladies and gentlemen.

**Mrs Sullivan:** —where quite incorrect analysis of what occurred at that meeting has gone in to the minister.

**The Vice-Chair:** I would ask speakers to speak one at a time and address the Chair.

**Mrs Sullivan:** That has nothing to do with community integration.

**Mr Jackson:** I guess you didn't like what I said about Elinor Caplan.

**The Vice-Chair:** The Chair, please.

**Mrs Sullivan:** Mr Chair, this motion contemplates one federated multiservice board, not agency. There are many models which in different parts of Ontario might be useful, and I'm going to reiterate.

Some of those models might include a federated model, where you have an integration based on a partnership of existing providers.

There is an institutional facility based model which we have seen work, by example, in places such as the Bayview centre, such as the Marianhill facilities in Renfrew county.

There is a service coordination model, the brokerage model, which was very much a part of the Liberal initial discussions. Many people had reservations about that model, and so be it. In some communities, however, that model may be the appropriate model to ensure that the right delivery of care is provided in the right way.

There is the ministry's provision of services, a totally different model, and in fact this bill contemplates that the minister can deliver services.

There are services which could be delivered through a board of health, which in many cases is what exists now.

When we see in a Tory amendment one specific model, what we're saying is that is not the appropriate

approach, that people within a region should have the flexibility and the freedom to say, within the boundaries of the goals and standards that are set by the Ministry of Health, what will best meet the needs of that community and how people can best be served.

If it means that the VON and Saint Elizabeth and other existing organizations that have been providing care and services for years and years in a community are the best way of providing that service, so be it, and if that's what the community decides it wants, it should have the flexibility to make that decision. In another community where the public health unit or board of health has been coordinating the services and has been providing those services, there certainly should be the option that it can continue to do that, or the community may well opt into that option.

But what we see as a major flaw in this bill is the government's determination to set one model of service delivery where one agency puts everybody else out of business, takes no account of community will, of the determination of people to gauge what is most effective in that community, and the minister just says: "No. We don't want that. We believe that we have to prescribe every single thing that must be done and how it must be done and who must do it and under what circumstances."

We think the policy, the standards, the guidelines and the regulations with respect to quality assessment and evaluation should definitely be described and in the legislation and prescribed by the minister. Those are the things that people across the province have to measure up to.

We also believe that there should be a basket of services that should be available everywhere in the province, and that no matter how those services are provided, no matter what the delivery mechanism, they have to be provided, and the board is responsible for ensuring that they are provided, and it is accountable for providing those services, but why does a board have to deliver every single service itself?

Once again, I say there are various models. The Tory amendment, which we are going to vote against, unfortunately only allows for one model, just as the government's own bill only allows for one model.

**Mr Jim Wilson:** I just don't see how Ms Sullivan comes to the conclusion that the Tory federated multi-service boards allow for only one model. There couldn't be a more flexible model. We're simply saying that existing agencies will get together in a partnership and tell us, government, what the best way is to deliver services, to provide assessment, to provide access and to provide governance. It couldn't be further from the truth, what Mrs Sullivan has said about the Tory amendment.

Secondly, we have to deal with reality in this committee. It's all very nice, Ms Sullivan, to give the remarks you just gave, which sound great, I'm sure, on television and to the people of this province, but the fact of the matter is you have no amendments that would allow for that. Unless you're prepared to join with us and vote against the MSA clauses as the government's proposed and gut this bill without proposing any other type of model—and as I said, we propose a very flexible

model—then this bill will fly with the majority NDP support.

**Mrs Sullivan:** Point of order.

**Mr Jim Wilson:** And for grandstanding without having your own amendments—

**The Vice-Chair:** Mr Wilson, there's a point of order.

**Mrs Sullivan:** If Mr Wilson had read our amendments, he would discover that in fact our amendments do allow for the kind of flexibility that—

**Mr Jackson:** Is that a point of order, Mr Chair?

**The Vice-Chair:** No, not really.

**Mrs Sullivan:** Well, I think that perhaps he should—he has misspoken, Mr Chair.

**The Vice-Chair:** Mr Wilson, would you complete your statement.

**Mr Jim Wilson:** I have read all the Liberal amendments. I've made notes on every one of the Liberal amendments. I stayed up last night quite late doing that, and I don't see that they're proposing anything other than simply tinkering with the status quo of Bill 173. You tinker around the edges. We come up with a new vision, a vision that was—well, it shouldn't be "new." It's a vision that was asked for by many, many of the major players in the system now, and it stands behind what we were asked to do and the goals and objectives that this bill should be trying to achieve.

As I said, in facing reality, reality is you can't just say in this committee that you're agin everything and think that at the end of the day the people of Ontario are going to get a piece of legislation that meets all of the wonderful things you talked about, Ms Sullivan. You have to bring forward suggestions within the context of the legislation, because reality dictates that something's going to get passed by this committee—it may be over our dead bodies, but it's going to get passed by this committee—and with the majority in the Legislature, the NDP are going to pass some form of long-term care legislation.

1520

We are attempting to convince the government in as constructive a way as we can that they've got some good goals here with respect to long-term care in the community-based sector but that the legislation as presented needs some major fixing. The government itself acknowledges that it needs major fixing. They've got an inch and a half of amendments here, for goodness' sake. But the government itself does not address the major issues that were brought forward by witnesses to this committee. One of them was the structure of the MSA and the overprescriptive and monopolistic, bureaucratic nature of it. Two was the 80-20 rule, again applying to the monopoly. Three was there's nothing about the telephone number or how the goal of one-stop access is to be achieved, really, other than a lot of flowery language about it, and a couple of other major points that we'll be talking about later.

So I reject the Liberals' grandstanding on this. I think that's awful. I think it's incumbent upon them to do more than tinker and to come forward with a model to support us in this. I'm disappointed to hear that, void of ideas, they're just going to say that communities should be

doing their own planning. With your amendments, Ms Sullivan, communities aren't going to be much further ahead. They're stuck with essentially the government's MSA model with a bit of tinkering. At the end of the day, that's what will be presented to Parliament, and at the end of the legislative session I imagine that's what will be passed if we don't get some help in this committee to bring in a better vision of a multiservice agency, which we are calling a federated board.

**The Vice-Chair:** Ms Sullivan, you had indicated previously you wanted to speak again.

**Mrs Sullivan:** No, thank you. I'm voting against this amendment.

**Mr O'Connor:** I think the point is being missed here by my friend Mr Wilson. Yes, there was some discussion around a federated model, and prior to the last round of consultation there was a federated model that was being contemplated. He hasn't been able to satisfy the concerns I raise around accountability in the form of this model he's got there, and I think it would be rather a difficult thing to have the level of accountability that's going to be necessary when you have several boards that the members would end up being accountable to. I find that would be extremely difficult.

He's talked about the federated models that appear to be evolving. The fact is that if the legislation wasn't before the House and wasn't before us right now and the committee hearings weren't continuing and we weren't moving forward with this, we wouldn't see this type of partnering. The partnering wasn't there five years ago. It wasn't there while the previous government was in office, or the one before that. It's nice to see this level of partnering happening. There's a lot of progress being made.

What we did hear in the last round of consultation, and 75,000 people were involved in that last round of consultation, was that they wanted to see an integrated model. A federated model is far different than an integrated model. There are vast differences. I know he disagrees with the arguments that were placed by the seniors' alliance when they talked about the administrative overlap, the 30%. But the reality is that with the federated model, you end up with many pieces of administration continuing, and we don't need to see all those levels of administration continue in a system that can be integrated, and at the end of it we'd see much better services being provided for the consumer. So the partnering that's continuing I hope is going to continue, and I think we're going to see that take place to a far greater degree.

**Mr Jim Wilson:** That's all wonderful to say, but the partnering can't continue much longer once this bill is passed because there will be no partners to partner. There won't be any VON. There won't be any of the service providers we're trying to say should be allowed to get together in a federated model. It will be a bunch of people who work for the new MSA. You're not allowing current service providers, the players in the system, to even be on the board of the MSAs. I don't know what sort of partnering there is when you're dissolving them, expropriating their services and putting them into a new

entity. You just can't talk that language when the bill does not allow for it. It may sound good, but it's not truthful. It's not forthright with the people of the province to say partnering will continue.

Right now, with this bill looming over them, groups are not in a particularly great humour. The VON is being forced, through the auspices of the DHCs, whether it likes it or not, to begin to wind down its operations and figure out how to sell its fleet of cars to the government. There's no partnering going on as we get down to the wire. There was, I would say, over the last couple of years, as groups got the message that government wanted coordination. I think that for your own good and the good of the province you should now back off, change this bill to simply set the parameters which you expect local communities, in a general way, to include in their plans for the delivery of service and in their plans for the coordination of service and allow them some time to truly partner and come back and tell you.

In the meantime, the only thing you have to do—you don't even have to do it, but in the context of this bill, if you want some bill to pass so you can go to all-candidates' meetings and say, "We did long-term care reform," I'll give you that, if that's what you want to do. But let's not hamstring these people and let's not talk about partnership when you're dissolving all the partners. There'll be no partners left out there, partner, once this bill's in effect. I just reject your language. It's irrelevant to what you're actually doing in the legislation.

**Mr Jackson:** Just one brief comment: I wanted to indicate that this is going to be a difficult process, Mr Chairman. We only have three days in which to complete this. You've been very generous by allowing us to deal, in the purpose section, with this kind of detail.

**Interjection:** Committee of the whole.

**Mr Jackson:** We have committee of the whole House, but I want to make a statement here, because our party has clearly signalled that we want to get, somewhere, recognition in this legislation for a federated model.

It's apparent, with the vote about to occur, that we're going to lose that argument. We have not given up entirely on this bill until such time as the government has indicated an absolutely closed mind, closed shop, and we will not have any room for any kind of accommodation for these kinds of flexible models. That's why we're spending the time we are now.

We don't wish to be obstructionist to the course and the direction of this bill. We came here having invested seven years of our time—at least I have invested seven years of my legislative time—on this legislation and we've come to this point where we're no further ahead in terms of a flexible model. It's important that we don't undermine long-term care reform in the process.

1530

I frankly was disturbed by a recent comment. I'm following up on Ms Sullivan's comments. We have not, as a political party, indicated any obstructionism towards the long-term care reform. We're concerned about three key elements of this bill and we wish to fight tenaciously

for what we believe in, which is what my colleague and I are doing. I'm disturbed to find that Lyn McLeod—I'm not going to put words in Ms Sullivan's mouth—announced in the Hamilton Spectator just last week, for a party caucus meeting, that she promised the new law would be repealed if she became the next Premier.

I just want to indicate that I will respect where the Liberal Party's coming from, but in the process of the Conservative Party trying to salvage and make this bill better, we're trying to do that with amendments that have come from, as I say, seven years of work on this. We're not prepared to make such bold and dramatic statements, for headlines, that we're going to repeal this bill when we haven't even finished our three days of clause-by-clause or maybe two more days of House time.

Frankly, the fact that the Liberal Party won't support any mode of a federated model is unbelievable to me. If Ms McLeod, as the leader of the Liberal Party, has publicly pronounced, as I believe she has, in the Hamilton Spectator, that she's going to repeal this bill, I'm at a loss to understand the nature of the amendments that would undermine the effort we're trying to do when we're presenting motions, directly on the table of these discussions today, that come from the VON, from the Red Cross and numerous other agencies. We're prepared to take our defeat, but I believe we have the right to try to present them as clearly and as honestly as we receive them from those people who for seven years have been pushing for this kind of reform.

We will argue tenaciously on those points, which is this point; others we will be prepared to work with the government on to try to salvage elements of this bill. But we're not here to simply suggest that at the end of the day we're prepared to repeal it.

**Mrs Sullivan:** On a point of order, Mr Chair: The reporter who wrote this particular article is a person I know and who was writing for the Spectator. The indication Mr Jackson has provided to the committee, that the leader of the Liberal Party indicated that this bill would be repealed, is an interpretation placed on the word "change" that was used by the leader, and the reporter understood that to mean "repeal." That is not our position.

**Mr Jackson:** Is that a point of order, Mr Chairman?

**The Vice-Chair:** No, it's not a point of order, it's information. Mr Jackson, would you like to continue?

**Mr Jackson:** I'd like to continue, because I checked with the Spectator and they indicated that that is the position of Lyn McLeod.

**Mr Dalton McGuinty (Ottawa South):** That's leadership.

**Mr Jackson:** You may call it leadership. I understand that within the Liberal Party the whole notion of leadership is confusing, at the moment.

The point I'm trying to stress is that I want to serve notice to the committee that we'll try to work with this bill. We have not indicated, as the reporter—I know Steve Arnold. Perhaps Ms Sullivan has a different view of his work, but he has clearly indicated in the article that Lyn McLeod would repeal it if she became the next

Premier. I suspect, with the senior citizens watching, the operative word here is "if."

**The Vice-Chair:** If there are no further speakers, we'll put the motion. All in favour of the PC motion re clause 1(d)?

**Mr Jim Wilson:** A recorded vote.

**Ayes**

Jackson, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Duignan, Frankford, Johnson (Prince Edward-Lennox-South Hastings), Malkowski, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Sullivan, Wessinger.

**The Vice-Chair:** Motion lost.

The next was alternate 2, a PC motion. I guess that's not presented at this time?

**Mr Jim Wilson:** Actually, it is, because it simply adds wording to the clause in the bill. It's there because we did somewhat anticipate that the government may not support our federated model, and therefore our backup position is the following:

I move that clause 1(d) of the bill be amended by adding "that shall make available and operate a telephone service which will enable a person to access information on all community services available in the community in which the person resides by dialling a single number" at the end.

Very clearly, this adds to the end of clause 1(d) in the bill. I just want to read clause (d). It says, "to simplify and improve access to a continuum of community services by providing a framework for the development of multiservice agencies." The PC amendment adds to that the requirement to make available and operate a telephone service. Again, this does not preclude other types of telephone service, TDD lines or whatever is required for people with a disability or hearing impairment. It attempts to put into this legislation, in the purpose section, what I thought we were talking about with respect to one-stop shopping, one-stop access for many, many years—Mr Jackson says at least seven years in his career—which was that people in areas would have a phone number to contact.

We are told that the reason the government really needs to tear down all the existing service providers out there is that people don't know where to call and there isn't one number to call. Don't sit here in committee, as someone suggested a few minutes ago, and tell us that you can't support this because it's talking about a telephone number. What the heck were we talking about over the last few years about one-stop shopping? Whenever you talked about one-stop shopping or one-stop access—and, Mr Chairman, I'm sure you'll back me up on this in your part of the province—inevitably within the first two or three sentences of that discussion you would talk about a common phone number.

People appeared before this committee and said, "We've already moved to set up a 1-800 number in our area of the province." I know there are discussions in my area of the province about setting up the one phone

number. This is an essential ingredient to coordinating access to these services, and I think to reject this in the purpose section is to reject a fundamental part of your own purpose for reforming this system. I would appreciate the support of all members and really can't understand why this was left out of the bill in the first place.

**The Vice-Chair:** Any speakers? All in favour of Mr Wilson's motion?

**Mr Jim Wilson:** Recorded vote.

**Ayes**

Jackson, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Duignan, Frankford, Johnson (Prince Edward-Lennox-South Hastings), Malkowski, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Sullivan, Wessinger.

**The Vice-Chair:** Motion lost.

Next is a PC motion re section 1(e) of the bill.

**Mr Jackson:** He was up all night.

**Mr Jim Wilson:** You'd wonder if anyone else did any other work on this bill, Mr Chairman.

**Mrs Sullivan:** It's interesting that we only received your amendments this morning.

**Mr Jim Wilson:** My apologies.

**Mrs Sullivan:** I'll tell you, we didn't have a chance to read your amendments until this morning because they weren't available.

**The Vice-Chair:** Did you have a motion to present, Mr Wilson?

**Mr Jim Wilson:** I do, if Mrs Sullivan would give me the opportunity.

I move that section 1(e) of the bill be struck out and the following substituted:

"(e) to promote equitable access to community services both across the province and within communities using a person's needs, consistent assessment and service standards, and a comprehensive community information and referral service."

One of the aspects this motion tries to introduce—you've just rejected the phone number, which is beyond me. I don't know what you're talking about any more with respect to long-term care and single-point access. As far as I'm concerned, both the Liberals and NDP have just gone into some other sphere right now, because you're not talking about what we've been talking about, what I used to write political speeches about, and that was one phone number for a community. I don't even know what we're talking about any more with respect to this bill.

This gives you an opportunity to talk about consistent assessment and service standards, comprehensive community information and referral, which I know were key ingredients whenever we talked about access to long-term care services. We were told that these were some of the things that were broken out there; therefore we've put it in a clause in the purpose section to ensure that the bill actually addresses some of those things that we're told are broken. I would appreciate all-party support on this.

**The Vice-Chair:** Speakers? None?

**Mr Jim Wilson:** Then, Mr Chairman, I want to back this up with the actual groups that asked for it and told us it was a key part of reform, and to do that I need the list.

**Mrs Sullivan:** Mr Chairman, while he's looking for his list, I should tell you that we will be supporting this amendment.

**Mr Jim Wilson:** Thank you, Ms Sullivan; that's very kind of you. Could I tell you who asked for this amendment? It's important. These blank faces over there just rejecting everything we come up with is not very helpful. Why do we have committee hearings? Why are we going through this?

The Metro—boy, I hate short forms—the Metropolitan Toronto Homes for the Aged division asked us to put in the purposes this type of motion. Their reasoning was that it would promote equitable access to community services within communities based on a person's needs and utilizing consistent assessment and service standards.

**1540**

Along this line, we were also asked by—sorry, Mr Chairman; tomorrow I will try to have these better coordinated. The Association of Community Information Centres in Ontario also asked us to promote equitable access to community services both across the province and within communities, using a person's needs, consistent service and assessment standards, and a comprehensive community information and referral service.

A similar request was put forward by—and this is the last one I'm going to mention at this time—the Federation of Provincial Non-Profit Organizations Working with Seniors in Ontario. This amendment comes from those groups and certainly deserves the government's support. I don't know how in the world you could see anything wrong with it; it's just good old common sense. I appreciate the Liberal Party's support.

**Mrs O'Neill:** I wonder if Mr Wilson could tell me how or why he dropped the "consistent eligibility criteria." I do like his words "consistent assessment and service standards," but I'm a little concerned about dropping "consistent eligibility criteria." I thought we could have agreed on that fundamental.

**Mr Jim Wilson:** We tried to cover that through "consistent assessment and service standards." I'm quite open if Ms O'Neill's making a suggestion that "consistent eligibility criteria" be placed here. The problem is that at the time of drafting I had no idea what the eligibility criteria were going to be and was unable to do it. You will find amendments later where we do agree with the government that eligibility criteria, given that the manual isn't done yet, given that the working group is still out, will be dealt with in the regs. But if there's agreement that it should be in the purpose clause here, I would agree with Ms O'Neill that it does seem consistent with the wording of the amendment and would be happy to add that wording if it would somehow bring the government on side to support this motion.

**Mr Jackson:** As a supplementary to that, it's just come to my knowledge that those working groups have all been cancelled and have been told there will be no

new meetings scheduled. That is cause for concern. It's not part of this process, but perhaps we could get some feedback later about that. At least two groups I've had contact with have indicated that no new meetings are being rescheduled, that the matter is now before the House and that was it. I noticed the parliamentary assistant looking at Mr Quirt for some direction here, but to the extent that's true, it requires some clarification. It's not part of the process, but it certainly doesn't help us in terms of getting feedback informally as to the progress being made and it certainly has encumbered us to a degree in terms of our amendments.

**Mr Wessinger:** Perhaps I will ask Mr Quirt.

But it seemed to me it's a question of language here. I certainly understand what's in clause 1(e), in the "consistent eligibility criteria." I understand what that means and I understand what "uniform rules and procedures" means, but I must say, looking at the language of the amendment, I have a great deal of difficulty understanding what it's supposed to accomplish, because the whole purpose is "to promote equitable access to community services." That's the overriding provision. As I said, I have some difficulty understanding how the language in the Conservative amendment would in any way make more clear what is to be provided or have any additional provisions.

**Mr Jim Wilson:** May I respond to that, Mr Chairman? To me, it tries to take what you have in your bill, Mr Wessinger, and expand on it and clarify. As we were saying this morning, it talks about "using a person's needs," so we do a bit of needs-based planning, "consistent assessment," which is, I thought, a key ingredient of long-term care reform, and "service standards...community information and referral service," which goes further than your clause 1(e) in the purpose section.

**Mr Wessinger:** I suggest that "uniform rules" would cover the aspect of "consistent assessment" in the process. Certainly, it's the intention to have uniform rules with respect to making sure that assessment procedures are consistent. I don't think there's any dispute that that's the intention: to provide that through the rules. But some of the other aspects mentioned in the clause don't really relate to access, in the sense that delivery of service should come under a different heading other than promoting equitable access; it just doesn't belong in there. That's about the only comment I could make on it.

**The Vice-Chair:** Mr Wilson, were you going to propose an amendment to—

**Mr Jim Wilson:** No, it's hopeless. Let's just vote.

**Mr Wessinger:** Mr Quirt was going to respond to Mr Jackson's comment.

**Mr Jim Wilson:** Oh, yes. I wouldn't mind hearing that.

**Mr Quirt:** To clarify, the program design work groups helping us out with a number of different aspects of design of the new system have not been cancelled or disbanded. Out of respect for this process and at the request of some of the members who were on those work groups, they wished the meetings to be postponed until the clause-by-clause hearings were concluded.

Their perspective was that some of them of course represent organizations that are suggesting amendments to the bill and it's difficult for them to sit down and talk about the MSA's design in its current form. They want to wait until this committee improves the bill and they have a somewhat more concrete frame of reference to work with. At their request, we said, "Fine, we'll postpone the program design work groups," but we need their advice and will continue to meet with them to get it.

**Mr Jackson:** I think that's misleading and I think it's dangerous.

**Mr O'Connor:** I'd like to ask my colleague, whose amendment is before us, where the difference lies—

**Mr Gary Malkowski (York East):** On a point of order, Mr Chair: I think the comment about it being misleading should be withdrawn.

**Mr Wessinger:** It's not parliamentary language.

**Mr Jackson:** I did not accuse a member of this Legislature. I accused a staff member. If he wishes to take me to court or challenge me in public, he has every right to do so. I believe his comments are misleading.

**The Vice-Chair:** You didn't actually have the mike at the time.

**Mr Jackson:** No, but Mr Malkowski has good ears.

**The Vice-Chair:** You made the statement that the information was misleading.

**Mr Jackson:** And I stand by the statement. I can say that about anybody I wish, as long as I don't accuse a member of this committee. Mr Quirt is here, at the pleasure of this committee, as a staff member. I disagree with the opinion he's rendered, based on the information I have.

**Mr Wessinger:** I think it's inappropriate to attack a staff member who's providing a professional—totally inappropriate.

**Mr Jackson:** The people he's imputing an ulterior motive to are not here to defend themselves, and I feel it's part of the democratic process for me to defend those to whom he's imputing motive behind the collapsing.

It has come as a surprise to Mr Wessinger, the parliamentary assistant, that the process has been suspended. At the outset it should be noted that the parliamentary assistant to the process is surprised by this. I'm simply suggesting that it did not come from those individuals who were participating in the process, that this was rather more a ministry directive. If Mr Quirt would like to rephrase his suggestion—but he has left the impression that this process was generated by those who were invited to work on the working groups, and that is not the information I have.

1550

**The Vice-Chair:** What I heard was "some members." Would you care to clarify so we can get to the bottom of the matter?

**Mr Wessinger:** I'd like to clarify.

**Mr Jackson:** The whole discussion's out of order, Mr Chairman, and I suggested that to you when I raised it, that it was inappropriate for it to be discussed. I don't know why the Chair called for clarification. I simply—

you acknowledged it—indicated that it wasn't part of the clause-by-clause process and I suggested Mr Quirt could get back to us.

**Mrs Sullivan:** Your colleague asked for the clarification.

**The Vice-Chair:** Mr Wessenger, do you wish to—

**Mr Jackson:** We understand. Mr Wessenger doesn't have to speak.

**Mr Wessenger:** I think it's appropriate that I should comment on the fact. I'm not surprised. I think it's quite understandable that if a group of people are participating in a process and there's some uncertainty as to what the legal framework is going to be, it's quite appropriate—in fact probably is appropriate—that people who are participating should put a hold on their activities in respect to anything that has a level of uncertainty to it. I think there's nothing inappropriate about that action being taken and it probably is the most appropriate action.

**Mr Jim Wilson:** Let's just make up and get on with it.

**Mrs Sullivan:** Yes, let's go. Can we have the vote, Mr Chair?

**The Vice-Chair:** We'll now proceed with the vote. Are there any other speakers to the motion at this time? If not, we'll proceed with a vote. All in favour of the PC motion regarding clause 1(e) of the bill?

**Mr Jim Wilson:** Could we do a recorded vote again, Mr Chairman, please.

**The Vice-Chair:** A recorded vote is requested. All in favour, please?

**Ayes**

Jackson, McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Those opposed?

**Nays**

Duignan, Frankford, Johnson (Prince Edward-Lennox-South Hastings), Malkowski, O'Connor, Wessenger.

**The Vice-Chair:** The motion's lost.

Government motion regarding clause 1(f).

**Mr Wessenger:** Since we have three amendments that are all the same, I'd be quite happy to let somebody else move it if they wish.

I move that clause 1(f) of the bill be amended by adding "effective and" before "efficient" in the first line.

This was suggested by presenters, and certainly we all recognize that we want an effective as well as efficient management.

**The Vice-Chair:** Discussion?

**Mrs Sullivan:** As all of our amendments are identical, I think we can proceed without any discussion.

**The Vice-Chair:** All in favour of the government motion regarding clause 1(f)? Opposed? Carried.

**Mr Jim Wilson:** Does that mean, Mr Chairman, that effectively all three parties just had a motion carried? Can we go away with our tails held high, saying, "Jeez, we agreed on one thing"?

**Mr Wessenger:** We've agreed on one other one.

**Mr Jim Wilson:** Jeez, how easily I forget.

**The Vice-Chair:** The next ones are a Liberal motion and a PC motion which are the same as the one passed. The next is a government motion regarding clause 1(g).

**Mr Wessenger:** I move that clause 1(g) of the bill be struck out and the following substituted:

"(g) to encourage local community involvement, including the involvement of volunteers, in planning, coordinating, integrating and delivering community services and in governing the agencies that deliver community services."

This amendment responds to concerns raised in the hearings that this bill does not adequately address the importance of volunteers. We felt it important to put it in the purpose clause and to recognize the importance.

**The Vice-Chair:** Any speakers? If not, those in favour of government motion—Mr Wilson?

**Mr Jim Wilson:** You can pretty well assume that there will be some speakers on this. I don't have any great disagreement with the amendment, but I did note another amendment to clause (g) coming up dealing with volunteers. No, there's stuff being done by both the PCs and Liberals with respect to (h) and volunteers.

But again I just want to say for the record I know that many district health councils, along with other groups, but the district health council in Hamilton-Wentworth asked for, I think, almost this exact wording—I hope I have that right—with respect to this. I think they wanted it to actually read, "to require local community involvement in planning, coordinating, integrating, managing and delivering community services." I'm just wondering why the word "encourage" is in there rather than "require."

**Mr Wessenger:** The reason the word "encourage" would be in rather than "require" is that there may be some communities where it is impossible for some reason to have that; people may not choose or wish to be involved. I can't imagine that happening, but there may be some communities where there may be a difficulty in getting the community involvement. I assume that's the reason for "encourage" rather than "require," because if you had it as a requirement and nobody wanted to be involved, as far as the consumers or volunteers, then it would be difficult to achieve if you had a requirement rather than "to encourage."

**Mr Jim Wilson:** Has the government in any way responded to the very serious charge out there that you're essentially wiping out volunteerism in this province? I was in Montreal two weeks ago and had an opportunity to talk with some of their health officials, and they reminded me that when the province of Quebec set up the CLSCs, I think they were called, a direct quote from one of the former government members, a Liberal member there, is that they killed volunteerism in the province of Quebec. It's not the first time I've heard it. I wanted to take the opportunity to hear it at first hand.

When they brought in a type of multiservice agency—now I agree it's a little different, but it had the same effect, and that was getting rid of players like the VON and Red Cross and that sort of thing in the government structures and the access points—they killed volunteers.

I think it's all very nice that the government wants to ensure that there's lots of language about volunteers in this act, but as far as I know the government has not in any substantial way responded to the very serious charge that it is wiping out volunteers in this province. In fact last night I attended a ceremony in my riding which was a volunteer recognition ceremony for heart and stroke people in New Tecumseth, or the Tottenham area, and without any encouragement from me, I can tell you, those people volunteered some very strong language about what the government is doing. I'm sure all members are hearing this in their ridings.

Volunteers, frankly, are quite angry out there that their services are in a way being rejected by government; in a way they're being told that they're no longer needed in the system and that those agencies that they are affiliated with now—the big ones, of course, being Red Cross or the Catholic Health Association of Ontario member agencies, religious organizations that deliver community-based services and administer those services—volunteers feel very rejected by this government.

I want the parliamentary assistant to tell us, since you went to the bother of paying Jane Leitch's group \$6,000 to come up with a Price Waterhouse study, what have you done to try to figure out what the effect will be on volunteers, given that there's been lots of evidence given to this committee that you simply will be wiping them out and that all the flowery language in the world, beginning with this phrase and other amendments that I see you're bringing forward, won't bring back those volunteers which the province of Quebec so successfully got rid of and regrets to this day?

**Mr Wessenger:** First of all, I'd like to comment that I don't think we've had any evidence of what the situation is in the province of Quebec; we've only had rumour and innuendo.

**Mr Jackson:** On a point of order, Mr Chairman.

**Mr Wessenger:** So I don't think we have any evidence before us in that situation.

**The Vice-Chair:** Just a moment, Mr Wessenger.

**Mr Jackson:** On a point of order, Mr Chairman: I would ask the clerk to check the record. I raised the issue and the parliamentary assistant undertook, through direction, that they would make an inquiry. Am I to understand that the parliamentary assistant did not respond, having given an undertaking to this committee that he would do that?

1600

That is a matter of record. It was directed through the Chair that he would undertake even a phone call—I recall the day I raised it in the House—and now he would suggest that all he's got is rumour and innuendo. He undertook a promise to this committee he would look into that. That's all we asked to satisfy us.

**Mr Wessenger:** I'd like to point out that we did make the inquiries, the ministry did make the inquiries and several telephone calls. They were unable to obtain any evidence with respect to the question of a loss of volunteers.

**Mr Jackson:** Then I would ask you, if that is your

report, to give us a more detailed report as to who you contacted in the Quebec government. I believe if that was the undertaking, then you should advise us who you talked to and who in the Quebec government indicated to you that no such report or no such circumstance occurred before we start calling the VON and all these other groups liars, because they have this information from their offices in Quebec. Their coterminous offices in Quebec reported this to them and we, in good faith, asked the parliamentary assistant, through the Chair, to look into it.

We would like the information as to who you talked to and who is suggesting that there were no adverse effects, because that's not what VON Quebec and Saint Elizabeth in Quebec have been saying to their counterparts in Ontario.

**Mr Wessenger:** I can ask Mr Quirt if he can provide any further information on that question.

**Mr Quirt:** I can confirm that yes, we did make inquiries with the province of Quebec. We have made inquiries with other provinces and are compiling a bit of a summary of the efforts to reform long-term care in other provinces that will be available to the committee this week.

On the subject of the volunteers in Quebec, we made specific inquiries as to whether there was a report that talked about the impact on volunteers. My understanding is that we didn't have any luck in identifying a particular study that related specifically to volunteers. If I'm not mistaken, our staff followed up with Mr Jackson's staff to see if there was a lead that we could follow up on to track down that study.

I can certainly find out precisely who we talked to in Quebec and, tomorrow morning if you'd like, try to deal specifically with the question of volunteer services in Quebec. I will commit to have a report from the other provinces available this week as well.

**The Vice-Chair:** Thank you. Had you completed your comments, Mr Wessenger?

**Mr Wessenger:** No, I think I'd just like to respond further to the question of volunteers. Certainly it has been very much the intention of this legislation to incorporate volunteers and incorporate consumers. The fact is that the whole process is a local planning process which involves local people in the development of the models. I would suggest that a good way to involve volunteers is to make them feel part of the process in developing the model.

The second thing is that certainly there are amendments that will be put forward which will put a requirement on MSAs to develop a program with respect to the development of volunteers. I would take issue with the comments made with respect to saying that there's going to be a loss of volunteers.

We had several people indicate that the whole question of the development of volunteers and the use of volunteers had to do with how they were treated, how they were appreciated and the whole question of having a definite program of recruitment, a definite program of training. All these aspects are very important in the development of volunteer groups.

We certainly recognize the need to make a major effort with respect to continuing to involve volunteers and we are confident that volunteers will play a very strong role with respect to the continued provision of community services in Ontario.

**Mrs O'Neill:** I'm glad to see the amendment, but I really do believe that there is a perception, and I think it's a very real fear that is there among many of the agencies that depend on volunteers, that things are going to change drastically. They don't know exactly how. The concerns that are being expressed to me are more along the lines that, at least for the next few years, the recruitment of volunteers is going to fall off drastically because people are not going to join shifting sands, and that's what we're into.

I, however, like the wording of this, if it's what I think it is, and that's what I want to ask the parliamentary assistant: "...volunteers, in planning, coordinating, integrating...." does that emphasize the governance area of volunteerism?

**Mr Wessenger:** Yes, it certainly would emphasize the volunteer aspect of community services.

**Mrs O'Neill:** Because that seems to be a very grave concern, that the volunteerism will be lost to agencies. If that's what's included here, I think that we have attended to at least one of the concerns.

**Mr O'Connor:** I guess there are a couple of points that I'd like to make. I know that Mr Wessenger has pointed to the fact that there's an amendment to section 14 that again will stress the importance of the volunteer plan and the role the MSA as an agency must play in that area.

But I do have to take issue, regrettably, that one of my colleagues on this committee would try to undermine the validity of any agency that made a presentation to this committee. I'm referring to a comment made by one of my colleagues in regard to the work done by the seniors' alliance, Ms Jane Leitch. I think she's done some excellent work, and given that there are many different community groups out there that have received funding—even the OMA has received funding on occasion from the government—to try to discredit a member of an agency like that, I find really concerns me, and the fact that a committee member would challenge whether or not a reputable firm like Price Waterhouse actually did put together a good presentation.

**Mrs Sullivan:** Oh, oh, oh, shame.

**Mr O'Connor:** Other people might make want to make some issues with this, except that to have this come from a committee member—

**Mr Jim Wilson:** I'd like to make a point of privilege, Mr Chairman. I'd like to clarify, if offence was caused, I'm certainly not attacking Ms Leitch herself. I think she's a wonderful person and I've known her for quite some time. But I do attack what the group's conclusions were and the fact that it is no secret, and let's not mask it otherwise, you paid that group to get the Price Waterhouse study and—

*Interjection.*

**Mr Jim Wilson:** Don't get me in any more trouble

here—and that Price Waterhouse study is very poorly done. If Price Waterhouse wants to sue me for saying that, I'll back that up any day, because it doesn't take a rocket scientist to read that report and find out that many of its conclusions were erroneous or at least incomplete.

I think the whole thing was a front and I think shame on the government for using Ms Leitch and using her group to put forward your agenda. I think it was quite evident at the press conference, they're aware of the full agenda. They were unable to answer questions at the press conference with respect to anything in detail about the Price Waterhouse study, and I think in fairness to those wonderful people who are in good faith supporting this legislation, and there are very few of them—there's only Jane Leitch's group right now, and I shouldn't use her name. It's the seniors' consumer alliance.

It's the only group out there in isolation, and I think shame on the government for using them as a front for getting its way with long-term care. I think that's where the disgrace in twisting public policy and the public policy development process in this province—the shame is on the faces of the NDP, not on Jane Leitch and company. I'm sorry they got used.

*Interjection.*

**Mr Jim Wilson:** I am sorry, you are using them.

**The Vice-Chair:** Mr O'Connor, would you please complete your statement.

**Mr O'Connor:** I appreciate that he wanted to jump in there. The fact of the matter is that I really am bothered by the fact that any member of this committee would make an attack on any of the presenters that have made a presentation to us, some of the groups that worked very hard and through a consultation process. Price Waterhouse had put together a report identifying some areas of savings. My colleague opposite disagrees with that. That's fine, but to come up and to call the work done by any group a sham, I think is inappropriate.

1610

**The Vice-Chair:** Mr O'Connor, just a moment, please. A point of order?

**Mrs Sullivan:** Point of order, Mr Chair: Could the member speak to the paragraph of the bill that we're debating.

**The Vice-Chair:** Thank you. Good point. Can we move on to the motion?

**Mr O'Connor:** Mr Chair, if I had the opportunity to make the comments—and you will recall that I was making the comments directly to clause 1(g) of the bill—without continual interruption by my opposition colleagues—it's really unfortunate. It just delays and causes problems. I appreciate there was an apology offered by Mr Wilson and we'll leave it at that.

**The Vice-Chair:** Mr Wilson, did you have anything further? I had your name down.

**Mr Jim Wilson:** No, Mr Chairman, not at this time.

**Mrs Sullivan:** Mr Chairman, as you know, we have subsequent amendments with respect to the recruitment, retention and training of volunteers, and the recognition of their services in particular. As this is the first time in

the bill that the word "volunteer" or even the concept of volunteer service has come forward, I want to say I'm pleased to see this amendment to the bill.

The purpose clause would be remiss without including a reference to volunteers. I think there isn't anyone in the room who doesn't understand, and most people in any part of Ontario understand, that without the drivers for the Red Cross and without the friendly visitors and without the Meals on Wheels volunteers, without people who assist with respite care, without people who participate in actual service delivery, without people who participate in fund-raising, which in fact raises about 30% of the operating budgets of community agencies, our existing services would not function. We've had a happy mix, frankly, between the volunteer sector and those people who are employed by agencies, who work well together and have a congenial working relationship in every part of the province.

I was quite taken during the hearings with the concern that was expressed by the Metropolitan Toronto United Way representatives who appeared before us with a very comprehensive and articulate brief. In the course of that brief, as you will recall—the presenter also happens to be a leader, an employee at the Canadian Centre for Philanthropy. One of the concerns that was expressed in the strongest possible terms was in fact the attraction of a centralized bureaucratic agency to volunteers.

The indication at that time was that if you look at the participation of volunteers in organizations throughout the province, what you will find is that the least number of volunteers, on a numerical and proportionate basis, are those associated with universities, community colleges and hospitals. Board governance is only one aspect of volunteerism, and that's in fact where we tend to see those volunteer activities. In hospitals we have an additional volunteer sector, which is the auxiliaries, and they provide extraordinary service, but it's a very different kind of service than we've seen in the long-term care sector.

I must say that despite all of the argumentation and so on about the Quebec model, the indications that I have had from Quebec, the indications that I've had from British Columbia are that the more and more that volunteer agencies are taken out of the service delivery picture, the fewer and fewer volunteers there are to serve the community. I find that deeply distressing. However, I do want to say that because for the first time volunteers will be included in the purpose clause, I am supporting this amendment.

**Mr Jim Wilson:** Very briefly, because the PC amendment that follows is similar, or at least the government amendment incorporates what we were contemplating in this section, we'll be supporting it. We'll not be introducing our clause 1(h) and would call the question right now on this amendment.

**The Vice-Chair:** All those in favour of the government motion regarding section 1(g) of the bill? All in favour? Carried unanimously.

A Liberal motion regarding clause 1(g), is it? Ms Sullivan, are you going to present?

**Mrs Sullivan:** I'm just wondering if the clerk would advise as to whether I should move a new section of the bill as 1(h), rather than striking out the motion that's carried.

**Mr Wessenger:** Yes, you should.

**Mrs Sullivan:** Thank you.

I move that the bill be amended by adding a new clause 1(h) as follows:

"(h) to enable each community to plan, coordinate, integrate, manage and deliver community services in order to meet its unique needs and culture."

For us, this is an important amendment and is complementary to amendments we've put with respect to the 80-20 rule, with respect to the four-year rule and with respect to subsections 13(2) and (3). Sorry, (2) and (3) are the 80-20. What we are attempting to ensure here is that in fact each community will have the obligation and will understand that the purpose of this legislation is to enable it—it's enabling legislation rather than prescriptive—will enable each community to determine which model of service delivery is most appropriate for the unique needs and culture of that community.

This is the purpose clause of the bill, and therefore the specifics occur laterally. However, as we've indicated in our somewhat lengthy debate on an earlier amendment that was put forward by the Conservative caucus, we believe that what we have heard through these hearings and prior to the hearings is an extraordinarily high level of concern about the single-delivery model that the government has put forward. As I've indicated, there are many ways that services can be most appropriately delivered in a community.

In my own community—Mr Jackson spoke about this earlier—there have been meetings and round table sessions and consultations with respect to the MSA culture and development, and in fact there is deep concern about which model would be the most appropriate: whether there should be a local model, a regional model, a specific MSA for children, the coordination of services from one to another, whether a satellite operation should be involved, what happens with the local health unit or the region which has been responsible for home care.

We saw in fact a perfect example of an existing MSA in Marianhill, or what would be an MSA in Marianhill, where there is a full range and a continuum of services that is being put into effect by a local community agency that has a specific culture to it, in that case a religious culture. The community will lose if that particular service vehicle is lost to the community and something else comes in to replace it, and the local people, whom we have spoken with and whom the committee has heard, have indicated that they don't want to lose that particular vehicle.

We have seen through Waterloo, where able representatives of that community have come forward and talked about how for years there has been a very strong working relationship between the volunteer agencies, and indeed some commercial agencies as well, in ensuring that the full range of service needs, to the best of funding abil-

ities, are met, and that improvements are consistently undertaken as much as possible, that quality is being monitored on a cross-agency basis and that the community really believes that it's coming to terms with what is the best model for that area.

1620

In southwestern Ontario, we certainly know that the London area is looking at quite a different coordinated model of general health and social services delivery and its conclusions may well be quite different. What we're saying here is that each community ought to determine what is in fact the best model of how services should be delivered to meet the needs of people in those communities.

I think you'll remember people from the Cochrane area and from northwestern Ontario, who said that this MSA model is not appropriate for that particular geographic area with all of the limitations that are brought to service delivery. In fact, one of the things they would be more interested in seeing is a comprehensive health organization that would merge long-term care into their delivery.

Frankly, I thought that was useful. I thought it was a useful intervention, that the people who put that before our committee had been very thoughtful about it. It was not a new concept to them. They'd been working on it, and what they will see now is that long-term care is separate from the other kinds of vehicles they have been planning to ensure that there is a comprehensive, coordinated and multidisciplinary approach to all aspects of health and social services for that particular area.

So what we are urging is that the government accept this amendment, which underlines the need for the vitality within each community to be recognized so that they will have the opportunity to plan, as is occurring now with district health councils, and then subsequently to coordinate, integrate, manage and deliver the services in whatever way is most appropriate to the unique needs and the culture of that community.

I hope that the government and the third party will understand that this is a significant amendment not only to the purpose clause, but will have a continuing effect through the remainder of the bill.

**Mrs O'Neill:** I do believe this is a fundamental amendment. What it does is it builds on the strengths that are there. We have heard from several district health councils across this province that as they're doing their work as mandated by the Ministry of Health, they are finding that there are successes. They are finding that there are real efforts to improve this system, to coordinate it, to integrate it in the way in which the community feels is in the best interests of that particular geographical, cultural or religious group.

What I find difficult about the manner in which the MSA model, and model only, is being imposed is the detail and direction that has already been given. In Ottawa, on the morning of September 12, we were given a sheet from the Ministry of Health that talked about the governance of multiservice agencies. On that same morning and throughout that entire day, every presenter

was given the same directive to the district health councils. That directive has caused a great deal of concern.

We have had some letters, and I think you, Mr Chair, likely got at least some of those letters, particularly from the municipalities where governance was an issue with them. Let's face it, in many of these municipalities the governance of the community health system, whether it be long-term care or broader, is of concern to them and in many cases they share costs.

What we find here is that we will involve real community members, not members who have to belong to some multiservice agency that nobody really knows how they're going to become members of, whether there are going to be fees involved in that or not. Actually, this directive to me is quite frightening and it is to many other people, because it talks about one staff person who's going to be hired by the original multiservice board and this one staff person then is going to have so much in the way of power to direct the foundation of a new service for the community in health care.

I feel very strongly that what we are doing is that we are destroying successes, we're breaking relationships, we're cutting bridges. These things do not develop overnight.

The communities are losing confidence, that something is being imposed that they don't think they can live with. This would give them the right to continue planning, certainly under the guidance of the ministry but certainly building on their successes, building on their relationships, building on their new perceptions of their role in long-term care reform.

**Mr Jim Wilson:** I think that one should support this motion. Don't take offence at this, anyone, but it is a little bit redundant in that it also talks about integration and coordination and a few other things that we just passed in the government's amendment to 1(g), and therefore I'm kind of surprised that you're allowing it as a separate section because it would repeat, I think, what we've somewhat done in 1(g) already, just passed. But as a point of principle I certainly agree with the Liberal colleagues here that this statement needs to be incorporated in this act to ensure that the message of this act is to give communities the greatest flexibility and leeway possible in planning and coordinating and integrating and managing and delivering those services.

Unfortunately, and it's the same problem I have as I'm sure my Liberal caucus colleagues do, is that unless the rest of the bill after the purpose clause and the bill of rights is dramatically amended, all of our nice purposes that we're now agreeing on won't amount to a hill of beans because they will become in effect ineffective, given that the government so far in its amendments hasn't indicated that it will move in any way to delete the reference to the 80-20 rule or delete the bias against the Canadian Red Cross and a number of other things that need fixing.

However, certainly in principle, I'm supportive of this legislation and understand what my colleagues are trying to do and I'm supportive of that.

**The Vice-Chair:** No other speakers? We'll put the

motion. All in favour of the—

**Mrs O'Neill:** A recorded vote, please.

**The Vice-Chair:** Thank you. All in favour of the Liberal motion?

**Ayes**

O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Duignan, Frankford, Johnson (Prince Edward-Lennox-South Hastings), Malkowski, O'Connor, Wessenger.

**The Vice-Chair:** Motion lost.

The government motion re 1(g.1).

**Mr Wessenger:** I move that section 1 of the bill be amended by adding the following clause:

"(g.1) to promote cooperation between providers of community services and providers of other health and social services."

I think it's clear that it responds to the concerns raised in the hearings that it's not clear regarding the principles of long-term care reform, which is to promote linkages between long-term care providers and others, such as hospital discharge planners.

The only comment I would have is I don't know whether legislative counsel would—this is purely an English thing, as I'm wondering if, rather than "promote cooperation between," should it be to "promote cooperation among"? That's the only—

**Ms Sibylle Filion:** I think both are equally acceptable.

**Mr Wessenger:** Both are equally acceptable; in which case then I'll leave it as is.

**The Vice-Chair:** Mr Wilson, did you wish to comment?

**Mr Jim Wilson:** I just wanted to indicate support for the amendment and note that people will find similar attempts to ensure that there is this type of cooperation between various service providers and various sites of service provision and between health and social services incorporated in some of the other opposition and third-party amendments. So I think, faced with this one coming up first, I feel very much obliged to support it.

1630

**Mrs Sullivan:** At another point the government has an amendment with respect to coordinating health and social services, or at least bringing them together, and we have an amendment to clause 1(j) which says, "to ensure the coordination of community services provided by service providers with those offered by hospitals, long-term care facilities, mental health services, health care professionals and social service agencies, and to promote a continuum of health and social services."

I don't think the Tories have one on this issue, but I think what's happening here is that we are all, each party, seeing a problem with the bringing together of services. I note that the government has used the word "cooperation." Here's the government's one, 1(c.1), which is carried, "to integrate community services that are health...with...social." Now we have, "to promote cooper-

ation between" the "providers," and our amendment is to ensure the coordination of services with those offered by basically health and other social service agencies.

I'm wondering why the government has chosen to use the word "cooperation" rather than, say, "cooperation and coordination" and why the government has not included the word "continuum" in this amendment. My sense is that because the Tories supported the government's earlier motion, and we have a similar motion to this in terms of philosophy, I think we're coming fairly close, but I'm wondering if the government would consider amendments to this to ensure that it's not only cooperation that we're looking for, but we're looking for very specific coordination of services so that there will be a real continuum of care.

**Mr Wessenger:** If I might just respond with respect to the coordination, certainly I'd have no objection if you'd like to move an amendment to add "to promote cooperation and coordination."

**Mrs O'Neill:** Yes, let's go with that then.

**Mrs Sullivan:** Yes, I will move that the government amendment to clause 1(g.1) be amended by adding the words "and coordination" after the word "cooperation" in the first line.

**Mr Wessenger:** I'll accept that as a friendly amendment.

**Mr Jim Wilson:** I appreciate that amendment to the amendment and am supportive of it. I just want to note for the record, because Ms Sullivan did sort of indicate, perhaps in a friendly tone that I missed, that the Tories don't have any amendments at this point in this area, that words like "integration," "coordination" and "continuum of community services" were used in our previous amendments, which youse guys, to use the colloquialism, rejected. So we made earlier attempts to do what is now before us. I just wanted to make that clear for the record.

**The Vice-Chair:** Ms Sullivan's amendment, then, adding the words "and coordination" to 1(g.1) following "to promote cooperation." All in favour of the amendment? Unanimous. Carried.

The motion of the government, as amended, 1(g.1), all in favour? Unanimous. Carried.

Next is a Liberal motion re section 1 of the bill.

**Mrs Sullivan:** I move that section 1 of the bill be amended by adding the following clause:

"(h) to promote recruitment, training and recognition of volunteers."

I'm assuming that legislative counsel will look after the numbering on this, but clearly what we wanted to do was to ensure that one of the purposes of the bill and one of the principles that's included in the bill is that volunteers are seen to continue to be an important part of our long-term care services, that they are not only included as somebody you have to go after and somebody you have to train and somebody you have to expect will deliver services but also as people who will be recognized in the community for the kinds of services they provide on a volunteer basis.

Now, there are several amendments on volunteers. I

believe the Tories have one next. We've had some words inserted by the government earlier under clause (g). The one thing that's missing so far in all of our amendments with respect to volunteers is the word "recognition." It seems to me that for all of the government rhetoric with respect to not losing our volunteers, one of the ways that you don't lose people who provide service of this nature is to ensure that in fact they are honoured for the kind of service they provide.

**Mr Wessenger:** If I just might comment on that, we feel that clause 1(g), as amended, passed, does recognize volunteers in the purpose clause. If we look at section 14.1, it does cover provision for the recruiting—so it covers recruitment—training, supervising, retaining and recognizing. "Recognizing" is right in the amendment, section 14.1.

**Mrs Sullivan:** In that case, I'll withdraw this amendment and accept the government's later amendment.

**The Vice-Chair:** Motion withdrawn. Did you wish to speak to this clause?

**Mrs O'Neill:** No, I'll wait until we deal with the government amendment then on section 14.

**The Vice-Chair:** Next is the PC motion to amend section 1 of the bill.

**Mr Jim Wilson:** Very quickly, I move that section 1 of the bill be amended by adding the following clause:

"(h) to maintain and promote volunteer involvement in the governance and delivery of community services."

Given that the volunteer involvement in governance and delivery has been dealt with in the government's previous 1(g) that was passed and agreed to unanimously, I'll withdraw this amendment.

**The Vice-Chair:** Withdrawn; thank you. Liberal motion regarding amending section 1 of the bill by adding (i).

**Mrs O'Neill:** I move that section 1 of the bill be amended by adding the following clause:

"(i) to enable communities to provide community services in different settings, including but not limited to community-based and home settings, and to offer a combination of settings and of service providers in order to better meet the needs of its residents."

We had representation from several groups regarding this matter as well and we place it in consideration of those presentations.

**Mr Wessenger:** I just think it's redundant. That's the only thing. I think it's covered in basically clause 1(c). Am I right here?

*Interjection.*

**Mr Wessenger:** Oh, it's covered in 1(a), so it would just be duplicating in a sense.

1640

**The Vice-Chair:** Those in favour of the Liberal amendment to section 1, adding (i)? Opposed? The motion is lost.

The next is a Liberal motion amending section 1 of the bill by adding (j).

**Mrs O'Neill:** I move that section 1 of the bill be

amended by adding the following clause:

"(j) to ensure the coordination of community services provided by service providers with those services offered by hospitals, long-term care facilities, mental health services, health care professionals and social service agencies, and to promote a continuum of health and social services."

We had extensive discussions on this matter earlier this morning and I place it in accord with those discussions. We still have quite a bit of concern about a continuum of care and the coordination with facilities, and that's what this motion and amendment is all about.

**Mr Wessenger:** I might suggest that the friendly amendment done by Ms Sullivan where we added the words "and coordination," combined with the fact that continuum of care is mentioned in another couple of subclauses, adequately covers the situation.

**Mr Jim Wilson:** I note that Ms O'Neill is quite correct that in this morning's discussions, particularly on a PC amendment, we tried to do very similar things, present similar wording to what's now in this amendment. This was earlier on in section 1 discussions, and members will recall we had a friendly amendment where Mrs Sullivan added long-term care facilities to the PC amendment.

My recollection is that this didn't fly at the time, and I think it is important once again that this motion be in the purpose clause. I don't accept that the specifics of this motion are already covered in the other purposes outlined in the act in this section. I think it's important that once again we get in a mention of mental health services, that we get in a mention of the coordination of all the various services and service providers in the community and beyond the community setting, and that we get some language in there about the continuum of health and social services. So I am very supportive of this amendment.

**Mr O'Connor:** I think that if we refer right back to our earlier discussion and take a look at the very first clause, "(a) to ensure that a wide range of community services is available to people," this is about the community side of long-term care reform. Yes, we can recognize there's a lot of work being done that's part of that whole continuum that isn't included in this, the long-term care facilities that are out there operating, the mental health services that are being provided in the community. It doesn't make mention of everything that is out there. I think we start getting into the very thing that we're accused of in being too prescriptive, and I certainly wouldn't want to try to become more prescriptive and then exclude things by putting more in there than what needs to be in place.

The importance here is that it's the community side of long-term care reform. I don't think that takes away from any of what's being done within the community, and I believe that amendments made earlier that talked about the coordination of the community services actually do address what this Liberal motion is trying to address. I believe it's already addressed, so I won't be supporting this motion.

**Mrs O'Neill:** I just want to add again that I'm really having difficulty with the government not accepting this, especially when they themselves placed an amendment regarding coordination and cooperation and talking about efficiencies.

This bill, however much some people here may not want to connect it, is very closely connected to Bill 101. The role of the placement coordinator from Bill 101 is going to spill over to the MSA as it's found in Bill 173. That's why I think this is so important, to show the communities that there is a continuum of care. That is one of the biggest fears of people out there, and particularly now with this bill on the horizon. They're really wondering what's going to happen between step 1, which is usually their entry into some kind of long-term care, and the steps that follow that.

In my mind there's absolutely nothing that isn't congruent with the intent of the government here, including falling in line with some of the amendments that were placed today by the government. I'm having difficulty understanding why this cannot be placed and emphasize that people are assured of the health care system they are expecting.

**Mrs Sullivan:** Mr Chairman, I don't know if this qualifies as a point of order or if I need to put an amendment, but unfortunately there's a drafting error in this amendment as put forward.

As it's been put, I would like to move that the words "service providers" in the second line be replaced by the words "multiservice agencies."

**The Vice-Chair:** Thank you.

**Mrs Sullivan:** I think that's self-evident, but I have reservations about whether in fact it is covered by government amendments that have been put with respect to the cooperation and coordination of health and social agencies. What we're saying here is that the multiservice agencies themselves will not have sole responsibility for all long-term care issues. That became very clear when we were speaking much earlier with respect to our amendment about long-term care facilities.

There are many services which an MSA will not provide that will be specifically provided through others with a specific responsibility and authority for that provision. We see hospitals, for instance, that have adult day programs, that have children's programs. We have children's treatment centres. We have long-term care facilities, which very frequently don't simply offer residential care but offer other kinds of programs that have a legitimate requirement to be linked with the home care and community service provision. We are still quite concerned that there isn't enough emphasis on that full continuum of service provision.

I understand the rationale for the defeat of our first amendment to this bill, but frankly, we think there has to be more of a spelling out of what quite specific services are where there has to be a linkage, where there has to be a coordination, where there has to be the seamless system that we all are striving for. That's what this amendment is intended to underline.

**Mr O'Connor:** Given the intention and the suggested

change made here by my colleague, my only fear would be that we could be limiting services, or the recognition in the purpose clause of this. I don't know whether it would, because I think you've got it worded fairly skilfully. Maybe I could ask legal counsel to respond to my concern that we might be in fact limiting ourselves by putting in a definition of this nature. I mentioned my concern about being too prescriptive, but I think she's actually crafted it quite well, and given that she has amended it, perhaps I could have that addressed, whether it is limiting or not.

1650

**Mr Wessenger:** I'll ask legal counsel since you specifically addressed it, Mr O'Connor.

**Ms Czukar:** I'm sorry, I just want to clarify the question. Is it whether the way it's crafted is limiting?

**Mr O'Connor:** Limiting, yes, in regard to the scope. It's to ensure the coordination of community services provided by the MSA with those services offered by the hospitals. It recognizes some services that are being provided out there within the community right now, that the MSA will take into consideration all of those as far as the continuum of care is concerned, is my way of reading this. If something isn't recognized in there, are we then placing a limit on possibly recognizing the value of what is being provided in there? That's my only concern.

**Ms Czukar:** I would say that by naming specific kinds of other services and other service providers, it is more limiting than the former amendment, which spoke about providers of other health and social services in general. This names some specific ones but doesn't include all providers of health and social services.

**Mr O'Connor:** In the end, "and to promote a continuum of health and social services" is kind of like the basket at the end of it all that catches what might be—where my concerns come in is the limitations. Are those words at the end of this amendment going to address the concerns I would have about limiting the services, in your legal opinion?

**Ms Czukar:** It wouldn't necessarily include all the other kinds of health and social services. The way I would read it is that if the services provided by the MSA were coordinated with these named services, that would promote the continuum of health and social services. That's the way I would read that amendment. It's not a new kind of purpose to promote a continuum in this context.

**Mr Wessenger:** Maybe I'll just add that I'm having difficulties with this provision because we just previously passed an amendment "to promote cooperation and coordination between providers of community services and providers of other health and social services." In my opinion, aside from the difference of the words "ensure" and "promote," "community services and providers of other health and social services" would certainly encompass everything that's listed in this motion.

To my way of thinking, it wouldn't make sense to have two purpose clauses where one is a lesser one of the all-encompassing one. It doesn't make any sense from a

drafting point of view, in my opinion, to add a clause (j) since we already have the essential aspect of coordination covered in a broad-based way. To me, it doesn't really add anything. It's sort of like, "We'll do (a)," and (a) generally includes everything else, and then we add some limiting aspects to it. It doesn't make sense to me to pass this amendment, because I think we've got the broad-based purpose.

**Mr O'Connor:** If I could use an example to help clarify this, developmental services, for example, aren't mentioned here, but there are services that aren't available or that haven't been named. I just wonder if those are the types of services we could be excluding by limiting ourselves by this.

**Mr Wessinger:** If I might answer that question, you might include, for instance, developmental services under social service agencies. To give an example, the one that was mentioned earlier, children's treatment centres are not mentioned but they would be under the provider of—

**Mrs Sullivan:** Social service agencies.

**Mr Wessinger:** No, I would call them a health agency, the children's treatment centres.

**Mrs Sullivan:** They're under Comsoc.

**Mr Wessinger:** They're funded by our ministry. That's just an example I thought of that would be excluded. As I said, I think we're covered with what we already have, so why add something that's unnecessary?

**Mrs Sullivan:** My colleague has pointed out that the difference with this amendment and other amendments are the words "to ensure," rather than "to promote." What we're saying is that the linkage between these agencies is that much more important. I certainly know that in my community, where we have the lowest number of long-term care beds in the province and an inadequate number of community services, the difficulty our hospitals have when they are under pressure to release patients to the community to improve their funding position is that there's no place for people to go. The services simply aren't available.

What we're saying is that those issues have to be coordinated. They have to be coordinated very specifically, because if persons are discharged from hospital and the other services don't exist, you can bet they'll be back in that hospital and the costs are much, much greater. We're saying that the issue of ensuring rather than promoting puts a higher test, if you like, to this clause.

**Mrs O'Neill:** I'm having difficulty with the government not accepting this motion, because it states what has been stated over and over since we began meetings in mid-August. It really talks about the referral system or the ability of groups to communicate with the MSA and from time to time purchase service from the MSA. Why the government members, through the parliamentary assistant, would say, "No go," is impossible for me to believe. As late as this morning, we were guaranteed that there would be referrals regarding mental health. Now it seems that there's a real aversion to even putting the words "mental health" anywhere in this bill, even in the case of referral.

I hope the government members realize that this would

allay so many fears in the community. I can't believe that they don't want to allay fears through this bill, that they just want to add fuel to the fire of fear that's in this province regarding this bill. I really can't accept that they will not try to allay fears, even if it means rewording this slightly, that there is a continuum of service, that there is going to be coordination, that everybody's not going to be in their own little camp, community health care here and facilities and institutional care there. That's all this motion is saying.

**Mr O'Connor:** I'm trying to work with my colleagues on this. With the last motion we moved, I suppose if we had had some of this discussion, we could have put in there "to promote and to ensure the cooperation and coordination." We could have thrown a few more "ands" and "ensures" in there that might have covered this all off. The two clauses seem pretty darned close to me. I wonder if legal counsel can say what the impact would be in having both motions or both amendments in the bill. They do somewhat complement themselves, but it almost seems somewhat redundant, but not really, you know. If legal counsel could comment on that, I'd appreciate it.

**Mr Wessinger:** I think this question you're asking is to legislative counsel. It's not really my position to refer, so if the Chair could—

**The Vice-Chair:** Do you wish legislative counsel to—

**Mr O'Connor:** Legislative counsel.

**The Vice-Chair:** Respond, please.

**Ms Filion:** It's difficult to have a definite answer on this kind of question, especially since we're in the purpose clause and we're sort of into generalities. So long as the two clauses aren't contradictory—that to me would be the only limitation in having the two clauses in the bill. As to what the difference is between promoting and ensuring, if I had my dictionary with me—perhaps one is stronger than the other. It's a question of degree, but I leave that to the committee.

**Mr O'Connor:** We did have "to ensure" in clause (a)"

**The Vice-Chair:** First we need to deal with Ms Sullivan's amendment to the Liberal motion by changing the words in the second line, "service providers," to "multiservice agencies."

All in favour of the amendment to correct—

**Mrs Sullivan:** Come on, come on.

**The Vice-Chair:** It's correcting her motion.

*Interjections.*

**Mr Wessinger:** Oh, multiservice agencies.

**The Vice-Chair:** Yes, it's correcting her motion.

**Mr Wessinger:** Okay, correcting.

**The Vice-Chair:** Unanimous, I believe.

Now, the Liberal motion to amend section 1 of the bill by adding (j). All in favour?

**Mrs O'Neill:** Recorded vote.

**Ayes**

Frankford, Johnson (Prince Edward-Lennox-South Hastings), Malkowski, O'Connor, O'Neill (Ottawa-

Rideau), Sullivan, Wessenger, Wilson (Simcoe West).

**The Vice-Chair:** Opposed? The motion is carried.

**Clerk of the Committee:** Mr Duignan has to vote.

**The Vice-Chair:** Oh, did he not vote? Mr Duignan, would you cast your vote, please.

**Mr Noel Duignan (Halton North):** Oh, sorry.

**The Vice-Chair:** So he's voted. Thank you very much.

**Mrs Sullivan:** What did Mr Duignan do?

**The Vice-Chair:** He voted in favour of the motion.

**Mrs Sullivan:** Oh, did he?

**The Vice-Chair:** Yes.

**Mrs Sullivan:** We just want to tell all the folks in Halton.

Mr Chairman, I know it's two minutes past 5, but we have just received a document from the Chiefs of Ontario. Some of this material was not included in presentations to the committee; however, some of it is of some concern with respect to treaty rights, the non-derogation clauses and so on. I wonder if legislative counsel could provide us with a written briefing so that we don't have to interrupt our clause-by-clause discussions tomorrow with respect to these particular recommendations.

Some of this is material that may be quite important as we're going through this so that the bill doesn't have to be reamended. For instance, now they have one recom-

mendation with respect to the purpose clause, which we're just coming to an end on, that would enable the minister to support first nations in the exercise of jurisdiction over long-term care services for their members. That's comparable to one presentation we had, but subsequent recommendations are new to us because they're quite legalistic and I think that we should know what we're looking at, because they well may be quite important in terms of whether this thing works or not. Perhaps I could just ask for some background for all the committee for tomorrow.

**The Vice-Chair:** Thank you. Referred to legislative counsel.

**Mrs Sullivan:** If possible, for tomorrow?

**Ms Filion:** Before I undertake to do anything, could I speak to Mrs Sullivan a little bit more about that perhaps?

**Mrs Sullivan:** Sure.

**The Vice-Chair:** Okay, fine. We need one further motion and that's to approve section 1 as amended. Do we have a motion to that?

**Mr Wessenger:** Yes.

**The Vice-Chair:** All in favour? Carried.

The social development committee, presently dealing with Bill 173, clause by clause, now stands adjourned until 10 am tomorrow morning.

*The committee adjourned at 1703.*



## CONTENTS

Tuesday 25 October 1994

**Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,**  
projet de loi 173, *M<sup>me</sup> Grier* ..... S-2369

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair /Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

**\*McGuinty, Dalton** (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

Rizzo, Tony (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Duignan, Noel (Halton North/-Nord ND) for Ms Carter

Frankford, Robert (Scarborough East/-Est ND) for Mr Rizzo

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

Johnson, Paul R. (Prince Edward-Lennox-South Hastings/Prince Edward-Lennox-Hastings-Sud ND) for Mr Martin

Lessard, Wayne (Windsor-Walkerville ND) for Ms Carter

Malkowski, Gary (York East/-Est ND) for Mr Hope

Marchese, Rosario (Fort York ND) for Mr Hope

Sullivan, Barbara (Halton Centre L) for Mr Beer

Wessenger, Paul (Simcoe Centre ND) for Mr Owens

#### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Wessenger, Paul, parliamentary assistant to the minister

Quirt, Geoff, acting executive director, long-term care division

Czukar, Gail, counsel, legal services branch

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Filion, Sibylle, legislative counsel

C1701  
X612  
-57-

S-73



S-73

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Wednesday 26 October 1994

# Journal des débats (Hansard)

Mercredi 26 octobre 1994

Standing committee on  
social development

Long-Term Care Act, 1994

Comité permanent des  
affaires sociales

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

*1944–1994*

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Wednesday 26 October 1994

Mercredi 26 octobre 1994

*The committee met at 1010 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Vice-Chair (Mr Ron Eddy):** Good morning, ladies and gentlemen. Welcome to the social development committee, which is considering Bill 173, An Act respecting Long-Term Care, clause by clause.

**Mrs Barbara Sullivan (Halton Centre):** Mr Chairman, as a result of information that came to the committee yesterday from the first nations and meetings I had yesterday afternoon—I believe government members will be discussing the issues with first nations people today at noon; I don't know when the third party will be meeting with them.

**Mr Jim Wilson (Simcoe West):** At noon.

**Mrs Sullivan:** At noon as well? We are drafting some amendments to put forward, one or two of which will affect section 2, which is the next section we're moving into. I'm going to ask that those sections be held open, rather than having votes on those sections, until we can have some discussion of the issues that are put forward.

My sense is that the minister has been negotiating and continues to negotiate with first nations with respect to specific agreements on long-term care delivery and that this bill does not accommodate any agreements that would be made. We should certainly at least have the discussion. I understand that it's late in the game for these to come forward, but I believe the council of chiefs has spent substantial time on it and that it merits having them put forward.

**The Vice-Chair:** So it would be in order to proceed with those amendments to section 2 that we have before us, I believe. Is that correct? Mr Wessinger, do you wish to comment on that matter?

**Mr Paul Wessinger (Simcoe Centre):** I think some of the amendments will have to be, by agreement, stood down; for instance, the ones relating to the first nations. I know there's a PC motion. I think we should leave section 2 ultimately open to allow for any possible amendments at the end, but we can deal with the amendments that are not relevant to first nations.

**Mr Jim Wilson:** For the record, we certainly agree with that. We had prepared a couple of PC motions on behalf of the first nations, but as meetings are pending, I would agree that we have all-party agreement to deal with those at an appropriate time.

**The Vice-Chair:** Is that agreed? Thank you.

We will now proceed with amendments to section 2. The first is a Liberal motion regarding subsection 2(1).

**Mrs Sullivan:** I move that the definition of "agency" in subsection 2(1) of the bill be amended by adding the following clause:

"(b.1) a corporation without share capital that is incorporated under part II of the Canada Corporations Act, and that is carried on without the purpose of gain for its members."

This amendment is a significant one in that it would enable the Red Cross in particular, and quite specifically, to be recognized as an agency and therefore subsequently to be recognized as an approved agency, items which cannot occur now under the terms of this bill.

Red Cross, because of its particular incorporation status, is left out of long-term care despite the fact that it has a lengthy and honourable history of providing home care and homemaking services throughout this province. We feel it's a real slap, first of all, at the kind of service the Red Cross has provided over the years for it not to be included, for it not to be able to be recognized as an agency or an approved agency, to be left out simply because of the method in which it's incorporated. It isn't enough, it seems to me, for the government to argue that the particular organizing structure of an organization which has a history of service and community involvement is such that it should be precluded from the activities it has carried on over a period of time.

There is an enormous volunteer component to Red Cross activities. The Red Cross is known as a fair employer for its own employees. The work they have done in homemaking and home care is exemplary, and in many cases it's the only service that's available in a community.

For the government to cut the Red Cross out of any involvement in service provision, particularly as an agency or as an approved agency, is something that is unconscionable and should not be accepted. I don't believe the people of Ontario ever foresaw that the Red Cross would be left out of an opportunity even, in certain circumstances, to become an MSA. Whether or not that would happen, it seems to me that it shouldn't be precluded at the beginning of the process, but rather should be contemplated as the plans in a community are being developed with the participation of people in the community.

**Mr Jim Wilson:** Members will note that the PC motion to follow is identical to this motion from the Liberal Party. Therefore, we are in agreement with the

Liberal motion. However, this amendment alone does not get the Red Cross totally out of hot water. I just want to remind members of what the Red Cross told us in its submission in Hamilton on August 18, 1994, from the Canadian Red Cross Society. I have a couple of paragraphs I want to read to explain why incorporation is only one of the problems they have and prohibits the Red Cross from participating in the MSA structure as proposed by the government. On page 9 of their brief of August 18, it reads:

"The legislation, as it is currently drafted, precludes the Red Cross, its regions, branches or programs from becoming an MSA or providing services as part of an MSA. Notwithstanding, the Red Cross is committed to meeting the needs of vulnerable members of our communities, building on the range of services that we have developed over the last 75 years.

"The Ontario division of the Canadian Red Cross Society is not a distinct organization, but is a part of a nationally incorporated entity, the Canadian Red Cross Society, which in turn is part of the International Red Cross and Red Crescent Movement. The Red Cross has had a long history of effective and efficient service throughout the world.

"There cannot be more than one Red Cross in any country. We operate under the bylaws established by the society. These bylaws describe authority and organizational structures and set parameters for our operation. The society has only one board of governors. This board is ultimately responsible for the overall direction and operation of all aspects of the society. No agreement or arrangement may be entered into that will in any way diminish the authority of the society's board or impinge on the society's fundamental principles, particularly:

"Independence: The International Red Cross and Red Crescent Movement is independent. The national societies, while auxiliaries in the humanitarian service of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the movement."

Finally, they note on page 10 under the principle of unity:

"There can only be one Red Cross Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

"The legislation requires that each MSA be incorporated under the Corporations Act, Ontario, or the Co-operative Corporations Act, Ontario. Each MSA must have its own board of governors selected in accordance with the act. These requirements are incompatible with the fundamental principles and corporate structure of the Canadian Red Cross Society."

That's the end of the quote from the brief. Essentially, in a nutshell, incorporation is one problem. The second problem is that the structure of the MSA boards would also preclude the Canadian Red Cross from becoming involved in the MSA structure, as will the 80-20 rule, which we'll be discussing in depth, I'm sure, in a few minutes.

Therefore, I would also ask members to note the PC motion for clause 2(1)(c.1) which also alters the definition of "agency" and gives a specific mention of the Canadian Red Cross in the same section that deals with municipalities and boards of health. That, in conjunction with the Liberal and PC motions dealing with incorporation, together should allow the Red Cross to participate in the MSA structure if the government proceeds with this legislation.

1020

**Mr Wessenger:** We will not be supporting this amendment. It's an essential ingredient of the MSA that we have to ensure we have community-controlled boards, that they have consumer representation, that they represent both health and social service perspectives, and also that they represent the diversity of the community. With a federally incorporated agency, there's no way we could have the jurisdiction to ensure that a federally incorporated agency would carry out those perspectives.

**Mrs Sullivan:** I would like the parliamentary assistant not to read from his notes and to explain to us why he believes that a federally incorporated corporation such as the Red Cross, operating in Ontario, with volunteer committees in every community, does not represent the diversity of the community and is not consumer-controlled. Who does he think these people are and where does he think they come from? I'd like further response to this. That is just the most ludicrous rationale I've ever heard.

**Mr Wessenger:** If we're going to deal with the Red Cross, look at the Red Cross specifically, the Red Cross has a federal board, a Canadian board of directors. That Canadian board is not reflective of the diversity of an MSA in Simcoe county or an MSA in Renfrew county. There's no way the provincial government can ensure the community accountability of one federal board. And the Red Cross is a hierarchical structure; it doesn't have local incorporated branches.

**Mrs Sullivan:** You take taxes from federally incorporated corporations.

**Mr Wessenger:** It's governed from a highly structured situation.

**The Vice-Chair:** Please, one speaker at a time. Had you completed?

**Mr Wessenger:** Yes, I have completed.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I hope Mr Wessenger and the NDP government have the money to put where their mouth is, because to buy out the Red Cross is going to cost them \$75 million, and then they're going to have all the severance cheques they're going to have for the Red Cross employees. That is the crassness of this.

The other aspect is that there are over 40 communities I have been in touch with, and there may be double that number, particularly in the north, that haven't got one other alternative but Red Cross for home care. All of a sudden, all those traditions, all those relationships with the existing physicians, psychiatrists, health care, community care workers, are going to be destroyed. This is going to be a very interesting exercise, to wipe out the

operation of the Red Cross in home care in Ontario. I don't think it's going to be a very pretty sight.

**Mr Wessenger:** If I might respond to Mrs O'Neill, she might look at our amendments with respect to the continuation of employment and the employment opportunities for those agencies that don't continue. Certainly we are protecting the employees. Those people will eventually be doing the same thing in a multiservice agency as they are presently doing. So there are going to be no particular severance packages because that is provided for, that employment is offered to an individual with a service provider by the MSA. There'll be no right to severance pay.

**Mrs O'Neill:** Severance pay isn't going to save this operation, let me tell you. You're destroying a mission, you're destroying a tradition, you're destroying a group of people who have gained the trust of many, many people in this province. I don't think your severance package is going to restore that, and I do not believe Bill 173 creates employment. I'm sorry.

**Ms Jenny Carter (Peterborough):** I feel quite strongly about this and I certainly don't support this motion. I have heard I don't know how many presentations from the Red Cross, both in my own home area and elsewhere. We all know they have done good work, that they have pioneered the field, that they have provided services where there are no services.

But it is the Red Cross's own structure that makes it unable to work in with what we're planning here. They have, as Mr Wilson described in full, an internationally based structure. They are not designed to fit into a grass-roots organization in a local area.

**Mrs Sullivan:** Get out. Oh!

**The Vice-Chair:** Please.

**Ms Carter:** As far as I can see, there will be no barrier for those same well-trained, caring people to continue to work where they have been working. It will not cost, as far as I can see, any money whatsoever, because there will be successor rights. Those people will be able to move over into working as they have been working under the MSA that will be set up in their area.

*Interjections.*

**The Vice-Chair:** Please, can we have order. I cannot hear the speaker.

**Ms Carter:** I would point out also that patients have never had the choice of whether they would have a nurse who was Red Cross, VON, Saint Elizabeth, whatever. All these organizations have done a good job, but that good job comes basically down to the individual employee who is working with the client. Some are better than others, obviously, and that devotion and that training will still be available under a much more publicly accountable system than has been the case in the past.

**Mr Gary Malkowski (York East):** I would like to respond to comments that were made by the member for Halton Centre. To the comments about the structure of the Red Cross, I'd like to share that in my own constituency the local Red Cross in East York is very positive, very proactive. They're working with the groups, they're working at the local level and working cooperatively. The

Red Cross people who work there have told me quite clearly that they are working quite well.

They're hearing that the provincial office is sending out direction and they're feeling it's conflicting with what they'd like to do locally, so what they need is the people at the local level to reflect what's happening locally. Red Cross has very good intentions in terms of people working in the north and having representatives there, and they do provide a service where there are gaps. But the Red Cross in my area is saying that they're working very well towards the implementation of an MSA, so my experience with the comments in my riding just don't jibe with the comments you're saying about the Red Cross in terms of what's happening locally. Maybe you're just listening to the comments from people at a provincial level and not listening to what's perhaps happening at a local level. I support what the parliamentary assistant said.

1030

**Mrs Sullivan:** I find it quite shocking that the government is being so hidebound with respect to the structure of an organization that is incorporated under the laws of our country and, simply because it isn't incorporated under the laws of our province, says it can no longer be involved, can no longer take its place as an approved agency in any community in this province, simply because it is incorporated by our federal government, by our national government, rather than under a provincial statute. I think that's absolute madness.

The function of the organization, which can be completely separated from the structure of the organization, is one that we are all familiar with, where there has been a record of service in virtually every community in this province. To say that the structure of the organization has limited it in any way in terms of the quality of care, in terms of the service provided, in terms of the accountability for its funding—and it certainly has received, and been open to receive, provincial moneys from time to time for necessary projects that are being undertaken in various communities—why all of a sudden does it not qualify? The government says it's because it will not have the authority to deal with the issues that are associated with Red Cross because of its particular incorporation status. Absolute nonsense.

The rules and regulations that are included in this bill are strong, they are clear, they are going to be demanding of any agency that is allowed to become an agency under this bill. The minister has authority to provide strictures with respect to the types of service that are offered, to require agencies to perform certain things in a certain way, to demand quality control, to demand financial accountability, and in fact all of those powers are included in this bill.

Don't try to tell us that the government would not have authority to deal with a Red Cross if it became an agency at a local level. It's absolute nonsense and in fact it's misleading. The bill would give the minister complete authority in every sense of the word and in every way that any other agency in the province would have that accountability. Red Cross, as an agency, would be just as accountable as any old MSA set up anywhere else.

I think the argumentations that the government is putting forward are just way out of line. They really fly in the face of the history and experience of every part of this province. It's just madness.

**Mr Jim Wilson:** This bill contains, for dubious reasons, as provided by the government to date, a three-pronged attack on the Canadian Red Cross, Ontario division. Not only is incorporation a problem—and the government's indicating now with this amendment that it is not prepared to budge on that—but also the fact that the board structure, as envisioned in the act, creates a barrier for the Red Cross to continue to exist in Ontario under an MSA structure, and the third prong is the 80-20 rule, that is, limiting all those service providers outside of the MSA to only 20% of the market in the delivery of community services.

Currently, the parliamentary assistant, Mr Wessinger, will know, the Canadian Red Cross in Simcoe county, I believe, delivers about 97% of the homemaking services in our home area. That home area is for Mr Wessinger and me. The Red Cross serves 130,000 people across this province. These people are the needy, the frail and the vulnerable people of our society.

The Red Cross depends currently on about 10,000 volunteers, and, by the way, we've had no explanation from this government of how it will replace in terms of dollars and time those thousands and thousands of volunteers, many of whom will not, and have told us very clearly they will not, volunteer for the government or for a perceived government structure or arm of the government called a multiservice agency.

**Ms Carter:** Nobody volunteers for hospitals.

**Mr Jim Wilson:** The Red Cross has 6,000 staff, many of whom will be displaced. The Red Cross will not be able to exist if the 80-20 rule, if incorporation, if the structure and board of the MSA go forth as in the government bill.

Again, other than having this ideological bias and some sort of grass-roots flowery talk about representation on boards by local communities, Ms Carter and Mr Wessinger have just essentially charged the Red Cross as somehow not doing a good job in serving the hundreds and thousands—

**Mr Wessinger:** On a point of order, Mr Chair: He's making an incorrect allegation with respect to what I said.

**Mr Jim Wilson:** Let me rephrase then. What is your problem with the Canadian Red Cross given that, as Ms Sullivan has pointed out, it is incorporated under our federal government? Do you have a problem with the federal incorporation?

The people who work for the Red Cross in Simcoe county, Mr Wessinger, live in Simcoe county. They're as grass-rootsy as you get. The people who volunteer are real people. They're real residents of Ontario. They're as grass-rootsy as you get. Maybe they're not your favourite NDP appointees whom you want to put on MSAs, but they're real people. They're breathing and living and volunteering and helping their neighbours and friends and the elderly and the frail.

To somehow say that this is wrong is the only interpretation I can take, that they're not accountable when they live in our communities, when they talk to their members of provincial Parliament regularly and are accountable with us to the people of Ontario. I want to know, again, why do you want to put Red Cross out of business, and all those volunteers? Why the three-pronged attack?

Will you budge on anything so the Red Cross can participate in your own model, which means either this amendment has to be supported for incorporation along with the change in the board structure, the membership of the board of MSAs, or, if you won't accept the first two, will you allow the PC motion which specifically allows the Red Cross along with boards of health and municipalities to become MSAs or, fourth, get rid of the 80-20 rule? In fact, if you got rid of the 80-20 rule, the Red Cross could continue, in Simcoe county and throughout the province, to provide services on a contractual basis with the MSAs and therefore you wouldn't have to tear down the Canadian Red Cross.

What are you prepared at all to give on any of those four points so the Red Cross can continue to exist? Because I tell you that people in Ontario are now starting to figure out what your social engineering is all about and they're getting quite angry. I think by the time this bill—and I hope people who are watching today pick up the phone, pick up a pen and paper and write the Premier, write the Minister of Health, phone their MPPs' offices, particularly the NDP offices—

**Mr Larry O'Connor (Durham-York):** Point of order, Mr Chair.

**Mr Jim Wilson:** This better be a point of order.

**The Vice-Chair:** Mr O'Connor.

**Mr O'Connor:** Thank you, Mr Chair. I appreciate that and I'm sure my colleagues won't mind me raising a point of order considering that they did that on several occasions yesterday.

**Mr Jim Wilson:** It better be a point of order.

**Mr O'Connor:** I'm sure that they don't have a problem with that.

My understanding is that we are dealing with a clause before us, a motion placed by the Liberal member that refers to section 2 of the bill. This isn't about free air time for political announcements to be had. We've gone through a public hearing process and we are now dealing with a clause-by-clause discussion of the bill.

**Mr Jim Wilson:** I'd like to respond.

**The Vice-Chair:** Just a moment, please. I'll decide who's speaking next. Thank you. You do not have a point of order. Would you please continue, Mr Wilson.

**Mr Jim Wilson:** This isn't a free political announcement. This is going to cost a lot of people their volunteer positions—

**Mr Cameron Jackson (Burlington South):** Their jobs.

**Mr Jim Wilson:** —their jobs and their services.

**Mr O'Connor:** In your simple mind.

**Mr Jim Wilson:** You know, what you're saying, and Ms Carter—

**The Vice-Chair:** Mr Wilson, will you address the Chair, please, and can we have one speaker only.

**Mr Jim Wilson:** Mr Chairman, what I'm hearing is that all of those representatives from the Canadian Red Cross who appeared before this committee during the public hearings, somehow it's in their minds—

**Mr Jackson:** Their simple minds, according to—

**Mr Jim Wilson:** —in their simple minds and in their lawyers' minds and in all the advice they're getting—

**Mr O'Connor:** That's a simple mind speaking right now.

**Mr Jim Wilson:** —and in the international board of the Red Cross and Red Crescent movement, it's in their simple minds that they won't continue to exist. That's a charge you cannot back up, because the facts are on the table. The facts are that you're wiping them out along with the VON, along with denominational services—

*Interjection.*

**The Vice-Chair:** Mr O'Connor, you'll have the opportunity to speak.

**Mr Jim Wilson:** —along with members of the Catholic Health Association of Ontario and other denominations.

**Mr Jackson:** You're calling them all liars.

**Mr Jim Wilson:** They cannot exist when you limit the market under the 80-20 rule, when you don't allow them to incorporate, as they must incorporate to exist. Why can't you have them budge on some of these points to allow the Canadian Red Cross to exist in Ontario?

**The Vice-Chair:** Thank you, Mr Wilson.

**Mr Jim Wilson:** I'd like an answer.

**The Vice-Chair:** Ms O'Neill.

**Mr Jim Wilson:** I'd like an answer from the parliamentary assistant, please.

**The Vice-Chair:** Yes, he will be answering. Ms O'Neill is next and then Mr Wessenger.

1040

**Mrs O'Neill:** In rejecting this motion, I think the only group of people in this province that is going to be helped is going to be lawyers. I really do think that in the actions that are going to be taken by this government against the Red Cross, there will certainly be many court challenges.

I really am having extreme difficulty with Mr Malkowski's presentation, or his intervention, I should say. We had 10 presentations from the Red Cross. We had them in Thunder Bay, we had them in Ottawa, we had them in Sault Ste Marie. In every case there was a common thread, that is true, but in every case there was a very local input of what it was going to do in that community, and particularly in the north the message was very clear. We're not just listening to the provincial association, I'm sorry, and I've met with most of those people.

There is a complete rejection of the fund-raising abilities of the Red Cross by rejecting this motion as well, and that goes right to the grass roots. If you want to talk about schools, most of us who went through the public and separate school systems of this province were

introduced to the Red Cross first. They set up a trend in a person to become much more altruistic. They have an ability to give a focus and to give a perspective that is unique to them.

I just feel that this is another cutting of successes by this government. Whether it's successes in long-term care in this province, successes in child care or indeed successes in auto insurance, it's just all wiped out with one wide brush by pieces of legislation that are presented by this particular group of people.

**The Vice-Chair:** Mr Wessenger.

**Mr Wessenger:** I do appreciate the chance to respond, and I think maybe we'll try to have a little more calmness and maybe hopefully—I'll try not to be inflammatory here, just to try to settle things down.

But I think we should recognize first of all that structures are means to achieve ends, and that when you look at the question of service delivery and how people receive that service, what's most important really to the people receiving the service is the people delivering it. That includes both the employees who do that and the volunteers who provide those services. It's certainly the intention to preserve that function and those people and those volunteers.

Whether you change a structure, changing a structure doesn't mean you're changing the people who provide the service. It doesn't mean that you're changing the way those people deliver that service. It doesn't mean that you change anything except the legal structure under which they're operating. I think we should all remember that.

It's certainly the intention for us to preserve and to retain those people delivering that service, to make sure they continue to deliver service in the same way and to make sure that these volunteers are doing the same thing as they're now doing, to value, to recognize how these volunteers work. So I think we should look at that, and then we look at structure.

Structure sometimes can be inhibiting or maybe inefficient in the way services can be delivered. If you're looking at what's the ideal way, we think, of delivering services in the community, it's having a community board, it's having a community representation, it's having that consumer representation on that board, and we think that's very important in a delivery system. We think that by making it more community-responsive, by preserving the same people, by encouraging the volunteers, we're going to have a better mechanism and delivery system.

Mrs Sullivan said it doesn't make any difference whether it's a federally incorporated corporation or a provincially incorporated. Unfortunately we have to recognize that legal differences do exist. In the case of a provincially incorporated body, we can define what must be in those bylaws. We can require the bylaws to be a certain way. We can control what provincial corporations do. We cannot control what a federal corporation can do.

The only way you could deal with a federally incorporated body, if you had one appointed as an MSA, would be to withdraw their approval as an MSA, and that would be the only action you could take, while there are many other courses of action you could take of a lesser extent

with respect to a provincially incorporated. So it does make a difference whether it's federally incorporated or provincially incorporated.

**Mr Malkowski:** I'd like to respond to the comments from Ms O'Neill, the comments that she heard from the different chapters of the Red Cross, specifically in the north. But I think you really missed my point. Looking at the Ontario seniors' alliance, they raised concerns about the lack of consumer mechanism for participation in the Red Cross, in the VON and in hospitals. They were concerned about how they could have an improved mechanism for participation so that the agencies could respond. But we haven't heard any response to the concerns by the Ontario seniors' alliance group for their participation.

Maybe your office has been receiving a lot of feedback from them, but they haven't been mentioned. I think we want to try and find a balance of the different perspectives of Red Cross and the other consumer groups. That's what we're here to try and do, to find that balance between all presenters on how we can best establish a system where the implementation of the MSAs can represent locally. We heard from the other groups. Perhaps you could clarify for me, did you receive any feedback or any concerns from the Ontario seniors' alliance?

**Mrs O'Neill:** If I'm to answer, I received the same correspondence as anyone else on this committee. I've also met with this group, I think, on three occasions, maybe more. I have been at their press conferences. What I do find is that I never saw once where the seniors' alliance asked that the Red Cross be eliminated. I don't think they understand it.

If I may just add my explanation to Mr Malkowski, the Red Cross—and I have spoken, as I say, to many of their groups and chapters; "branches" I think is the word it uses—have not involved the consumers because they don't want to create undue stress and pressure on the people they serve. The consumers that have been involved have, however, been the consumers that are on their boards right now and that are on the boards of VON. My leader and I met with a group of those people last week in Ottawa.

We also know that there are consumers represented in the coalition of 22 organizations that are really concerned about Bill 173. So to say that consumers have not been involved or to say that consumers were never involved in long-term care in this province is just not true.

**Ms Carter:** I think what we're really talking about here is a question of governance, who's going to have the responsibility for running these services. We need to get it absolutely clear what is being said on both sides here because I think there's a little bit of fudging. Bringing in volunteers is irrelevant to that point when you're talking about them actually delivering services, because they're going to be able to continue to do that now.

I understand that what the opposition parties are putting forward here is a concept of a federated service, where the agencies keep their identity and where the system would in fact be run by providers. What we are bringing forward is a system where power goes in some

degree at least to consumers and certainly to people in the local area. That is what this is all about.

That's why we had a big consultation, as you know. Something much more similar to a federated system was put forward originally. This was not approved by the—

**Mr Jackson:** By cabinet.

**Ms Carter:** —literally thousands of people who were consulted.

**Mr Jackson:** By cabinet.

**The Vice-Chair:** Please, you will have—

**Ms Carter:** What we have come up with is a system where the governance is firmly based at the local level, firmly community- and consumer-oriented, and what you are really saying with the amendments that you want to bring in is that this is not the way to go, that we should not have largely consumer representation deciding how this system will be run.

**Mr Sullivan:** That's a complete misrepresentation.

**Ms Carter:** The Red Cross is relevant here only because it is differently constituted to some of the other agencies, but as we all know, the plan is that they will all become more closely integrated, that the administration will be brought together and that this is where the savings and the integration that we've been asked to produce will come in.

1050

If we accept this amendment, power does go to the federal level. It leaves the level that we are trying to bring it to, which is the grass-roots level. So when you express your concerns about grass-roots input, actually you are talking on both sides of your mouth because you're trying to remove power from the local level at the same time that you are saying you support it. I don't accept that.

I think consumers do have a voice here because they are the people who know what they need; they are the ones who know when the service is not meeting those needs. I think their input is absolutely basic and crucial, and if we hear that denigrated, then that is a real indication of where your proposals are coming from where you do not in fact want this to be a democratic, grass-roots, locally controlled means of delivering health care.

**Mr Jim Wilson:** My interpretation of what's happening and what this bill represents is, I admit, dramatically different than the NDP's. They talk about more grass roots, yet we've been told and "communities say," but the bill is so prescriptive, I don't know what's left for communities to say.

As I said yesterday, I think the new boards of the MSA, with all of their local people on them, don't have much to decide, though. There's not a lot of flexibility in terms of essentially the services they must provide and who will provide them, ie, a monopoly is created. You don't have, as Mrs Carter is suggesting, integration. You've got annihilation. There is nothing to integrate when you get rid of the Red Cross and VON and that.

I don't think, and I say this as politely as possible, the government either understands, or it certainly is not willing to acknowledge, what they're truly doing. We are

told that because of particularly the 80-20 rule, there won't be enough business left out there for the Red Cross or the VON or Saint Elizabeth visiting nurses or Para-Med or Dolores Lawrence's group or many of those other private sector groups, any of the existing agencies, to continue to exist, because they won't have the critical masses, there won't be enough market share. They won't be able to provide the choice to consumers if the MSA structure and the 80-20 rule in particular go through, and all indications are so far that the government's going to go through.

So let's not talk nice, airy-fairy talk about integration. It's annihilation. They don't exist. You dissolve them and you make them into a monopoly. I don't know how the bill could be any clearer on that. I would venture to say well over 95% of the witnesses before this committee came forward and told us that's their interpretation of the act, and that will be the reality and it has been the reality in other jurisdictions where this sort of stuff has been tried at varying degrees.

Ms Carter spoke earlier about costs, and she denies there will be any new costs. I don't think, Ms Carter, the Red Cross is going to give the government its capital assets, its cars. I think those people, its employees that are displaced, are not going to walk away without severance packages. Your own bill refers, in the job security provision, that some of them will be hired, but if not, the Employment Standards Act kicks in and severance packages are given. So there's an anticipation of displacement there.

**Ms Carter:** But we're hiring more people. Remember that.

**Mr Jim Wilson:** That is cost. I don't think the VON's going to give you their fleet of cars, and if you remember, during the hearings we asked Mr Quirt, "Have you started to figure out how much it will cost to buy all those cars and capital assets of the VON?" So there are costs involved there with starting your new system.

You also spoke earlier about choice. Choice is annihilated.

**Ms Carter:** There never was.

**Mr Jim Wilson:** For some reason she says, and she says it again, there's no choice out there now. There are, by your own admission, hundreds of agencies to choose from. In my area alone, although the Red Cross, because of a coordinated effort, delivers most of the homemaking services, there certainly are choices. There are choices. If you don't like the Red Cross, you can go to another agency. You won't be able to do that when there's only one game in town, and that's the MSA. In fact, what you're doing is eliminating choice.

I would venture to say that the reason the Red Cross—I know it to be a fact in my particular area—happens to be delivering most of one particular type of basket of services, the homemaking services, is because they've made coordinated efforts with other agencies to say, "Look, we can do it best." I have never had a complaint from a consumer in 12 years in the business. I've never had a complaint about the VON or the Red Cross, I just haven't, and I read all of my mail and respond to it, and

I answer my phone calls, and I'm in my riding all the time. I grew up there. My family's lived there 168 years. I've never had a complaint.

**Mr O'Connor:** You wouldn't listen to a consumer advocate. All you do is badmouth them.

**Mr Jim Wilson:** I don't know why you want to get rid of the Red Cross. I think you'd want to enter into, and what we're trying to propose here is, a partnership relationship, which is your Premier's own talk all the time. Yet you won't budge on this amendment, and by the sound of it, on the amendments coming up, to also allow the Red Cross to continue to exist. You won't budge on it.

Mr Wessinger says, in the most agnostic terms I've ever heard in my life, that changing a structure doesn't mean much except in legal terms. What about the mission statements, the principles I read to you about the Red Cross, the principles of the Catholic Health Association of Ontario groups, the principles of the Anglicans and the Jewish communities and the linguistic and cultural communities that deliver these services? They have principles and values and missions such that when you change their structure and annihilate their participation in the delivery of services, it's more than a simple legal exercise.

I find it offensive that you fail to understand, and we failed in our mission to try and make you understand, and the witnesses have clearly failed in their mission to try and make you understand, that the unique identity of these groups, the Canadian Red Cross and the VON and our denominational service deliverers and others, is what attracts different people and different types of volunteers to volunteer for those different organizations. It's the choice of whom you volunteer for. It's the fact that Meals on Wheels in my area of the province is 100% volunteer.

Why do you want to just absorb that into the MSA, where you're going to have to start paying people to coordinate the program? Yes, you may retain some volunteer Meals on Wheels people, but the ones I've talked to have said they'd quit; they're not going to go work for the MSA. There are other agencies they can go to, like the Heart and Stroke Foundation of Ontario, which won't be part of the MSA, which are not community based or these types of community services. There are hundreds of other agencies they can go to, and I tell you, as in Quebec, they'll walk away. They'll walk away.

**Ms Carter:** All these principled people are going to walk away?

**Mr Jim Wilson:** Because there's lots of choice of whom to volunteer for out there, lots of choice, and they've been attracted for various reasons to the Red Cross or VON. We heard all kinds of testimony about what attracts them to those various missions of those agencies. You're eliminating choice.

**Ms Carter:** The needs of the people they serve are going to attract them.

**Mr Jim Wilson:** Volunteers are very much threatened by this, and I don't know where you get off at all saying that these agencies that exist in our communities are

somehow not grass roots. They're as grass roots and more aware, I would say, of the problems that they have to confront day to day on the front lines than you and I are as politicians. The nurses who work for the Red Cross, the homemaking staff of the Red Cross and their other employees are actually out there delivering services and dealing with our constituents face to face when we often talk to them on the phone. They're solving their problems.

I have never had a complaint and I can't say that about too many other things in society, because over the span of time that I've been in the business you're bound to have complaints about a lot of other things, but I've never had complaints. I've never had a senior say, "I'm not happy with the service I'm getting." In fact I've heard the opposite. My own grandmothers and family members have had the services of VON and Red Cross and homemaking services. Compliments have been many and frequent.

Where there are complaints, I assume the Red Cross must be responding to them, because they're not making them to my office and they didn't make them to George McCague's office, and, by God, people complain about all kinds of other things regularly. I'm sure my phone upstairs is constantly ringing, as it does all day, because my 1-800 lines are here at Queen's Park for my riding, so I'm in touch on an hourly basis with what's happening in the riding.

1100

You just don't have the justification. You want to control this thing. If you're talking about community, grass-roots participation on boards, then, at the other side, who's talking out of which side of whose mouth? Mr Wessinger talks about, "We need to make sure they're incorporated provincially so we can have government central control of these organizations." I think your case fails. I think that with the exception of the consumer alliance that Mr Malkowski correctly points out has a wish to proceed with the MSAs as envisioned in the bill—

**Ms Carter:** Well over a million people.

**Mr Jim Wilson:** I'm not sure that's true. We could get into that debate on exactly how many people they do represent because I'm not aware of anyone in my riding who actually belongs to the consumer alliance, but there might be a few. But the ones I've talked to, if they do—I've certainly talked to a number of very active people who may belong to the consumer alliance, and they tell me they don't want the Red Cross going out. That wasn't part of the deal of long-term care. They didn't know that's what they were asking for.

I agree with Mrs O'Neill. I think a lot of people are either naïve or are refusing to believe that keeping these distinct identities, keeping choice in the system—yes, better coordinated, yes, get those phone numbers in so that people can easily access the system and other methods of easily accessing the system, but don't tear down existing agencies when you've not made a good case that they are not delivering good service.

I think the truth out there lies in the fact that they're

doing a good job, that the Red Cross has been around for 75 years for the very fact that it is doing an excellent job in our communities. You've not made a case for getting rid of them.

**Mr Jackson:** I would hope that the—

*Interjection.*

**The Vice-Chair:** I'm doing it in the order that people indicate they wish to speak. I would like to remind you, Mr O'Connor, that we had three NDP members speak in a row.

**Mr O'Connor:** I know. That's what I'm saying: Going in rotation will be fine with this caucus.

**The Vice-Chair:** Thank you. It shall be done. Mr Jackson.

**Mr Jackson:** Thank you, Mr Chairman. What I was going to say was that I've listened to this debate, which seems to be bogged down with the Red Cross when in fact the Red Cross isn't the only agency that should be applied to the concerns raised in this clause. When you consider that certain native bands are federated on a national basis and incorporated on a national basis, the government may be, either in a manipulative way or in a direct omission, eliminating certain groups that could be eligible. I think it's unfair.

I've listened patiently to Mr Wessinger and to the NDP members who keep harping on the Red Cross, but there are other organizations. There are certainly Islamic organizations and Muslim organizations that are so relatively new in Canada that they hold national non-profit corporate charters. I think that although legal counsel was directed to examine this, it was done purely from the perspective of the legal relationship, that the government wanted clarification and this committee wanted clarification. At no point did we really look at who we were eliminating or forcing outside the circle of services by denying this amendment which would allow for representation for those organizations that hold solely national charters. I think we're being foolish, whether it is for a linguistic, religious or even a very small group providing services for the handicapped that has only a national charter.

I want to set that aside and I want to come to the Red Cross because I could contribute to this debate with stories from my community about all sorts of volunteers. I have a couple of people who phoned me last night. They're so angry and they've asked me to read their names into Hansard as people who are quitting. They're not going to volunteer for this agency. They're going to move their compassion. They're going to move their commitment. They're going to move their donation of their gasoline and the 50-cent coffees they buy for their seniors when they take them to their doctors. They're going to move all of those. They're not going to abandon them, as Ms Carter has suggested in her interjection. As the several who phoned me have indicated, they're going to do work for Community Living. They're going to assist the handicapped people in this province who are being overlooked in this legislation. They're going to help a whole host of citizens.

I don't think anybody should be suggesting that

volunteers will absolutely disappear into the woodwork. What they're going to do is leave this sector and move to another sector, and I want to give an analogy to the government members which I'm sure they will appreciate and accept with understanding.

You know, when Bob Rae got elected, he had, what, some 29%, 34% popularity in the polls. All these people supported them. They've invested their vote with him. He's now at 15% in the polls, and those 15% of people are not going to now not vote.

These were decent, honest, hardworking, principled people in the labour movement who've basically said, "I can't vote for Bob Rae in conscience any more because he's turned his back on us."

The volunteer sector is just like people who voted NDP all their life. They'll still vote, but there's been a break with the principles of how our society has been organized and operated, just as Bob Rae broke faith with the principles of a political party in this province that, quite frankly, had a very important role to play in this province. So volunteers won't disappear; they're just going to go somewhere else.

I want to address the final point on this amendment with respect to the Red Cross. What angers me is, I am not satisfied that the government isn't addressing another one of its agendas somewhere deeply embedded within the Ministry of Health. It is no secret that the Ministry of Health has been fighting with the Red Cross, the same organization we're dealing with, not on the issue of the services it's providing for seniors but on the issue of tainted blood.

This battle has been going on in this province and in this country, and it has not been a very pleasant battle between bureaucrats in Health ministries at the national and provincial levels and the unfortunate circumstances around the Red Cross, which is being assaulted on this issue. I cannot be convinced that this government isn't somehow making its point in the most dramatic, crass—

**Ms Carter:** That's an ugly word.

**Mr Jackson:** —cruel and inappropriate way possible.

I'm telling you that I am convinced that there is sufficient evidence that the government is stonewalling the Red Cross because of the negotiations that have been going on about tainted blood.

**Ms Carter:** It's the Red Cross's own constitution that is the problem.

**Mr Jackson:** It is not the sole constitution, because you're ready to turn your back on all sorts of organizations with national charters that provide services. For some reason the Red Cross is being singled out, isolated, targeted and is about to be dismantled for a major portion of its services in this province.

You have got to explain it better than how Mr Wessinger has by reading simple paragraphs prepared by staff talking about process changes. We're talking about huge losses of resources, human resources, a commitment from an organization that's taken hundreds of years to be built up.

And I'll tell you, there's a moral issue here. The moral issue is that when no government was prepared to

provide the direct services out of compassion and a desire to respond to needs in the community—

#### *Interjection.*

**Mr Jackson:** It doesn't matter what government it was. The fact is that the genesis of these services was when good, well-intended, open-hearted people came forward and said, "We'll fund-raise, we'll find the volunteers, we'll deliver the services to our senior citizens in this province," and the VON came forward, and the Catholic church and its agencies came forward, and all sorts of cultural groups came forward, and now we're going to say to them, "Now that we've used you to get the market opened up and to provide for the service, we're now going to discard you."

That is the issue here, and that is a moral question for a government that would do that to any group in society, and that's why the national component of the Corporations Act has got to be included in this legislation in order for a whole series of organizations that provide services that an MSA can acquire and that they can be part of and contribute, with their long history of service, to the planning and the integration and the success of the MSA models, which we want to support. We just are concerned that you are constantly taking people away from that table, not adding people to that table.

#### **1110**

**Mrs Sullivan:** It seems to me that if one is making any attempt to ensure progressive change, one ought to create the maximum opportunities for involvement, to utilize the experience, good and bad, out of the history of the area where change is required, to take advantage of expertise, to take advantage of the commitment to excellence that has existed in previous services and to ensure that there's a welcoming mat open, to ensure that attempts to create progressive change are inclusive rather than exclusive.

It seems to me that what's happening here and what every person in Ontario should understand is that the Red Cross is being denied, by the New Democratic government in Ontario, the ability to participate over the long term in progressive change and to be part of that progressive change. The Red Cross is respected in every single local community, it's respected provincially and it's respected nationally. Its volunteers spring out of our communities, from community roots, they reflect the priorities in the community in the work that they do in local Red Cross decision-making and they serve local people.

Across Ontario, 130,000 people who are now receiving services from Red Cross will not receive services from Red Cross because Red Cross will not be allowed to be an agency. Red Cross will not be allowed to be recognized. In other words, the government is saying that the Red Cross services that have been provided have no value. Those 130,000 people will in fact be having to look elsewhere when they have been receiving help from human beings who happen to be employed by Red Cross today. They will have to look for help elsewhere. Just because those service providers work for Red Cross, they will be taken out of this new approach to long-term care.

For years and years and years the quality of service, the volunteer activity have been exemplary. Now, in one fell swoop, the history and the expertise and the service and the commitment to service are being wiped out because this government says the Red Cross in Ontario has no value.

I want to particularly dissociate myself from the remarks of Mr Jackson with respect to the tainted blood issue. I do not believe there is a link in those areas and in that decision-making. However, I do believe that the government is taking a major misstep, is misreading the values in our community and is taking a fundamental attack on the culture and fabric of our volunteer agencies in each part of Ontario. I regret that. Clearly, they're not going to budge. They've dug in their heels, and goodbye, Red Cross.

**The Vice-Chair:** Mr Wessenger has requested to speak out of order to comment.

**Mr Wessenger:** Just to make the point that they should be aware that there's nothing in the act that prohibits the Red Cross from being a service provider. I just wanted to make that clear on the record.

**Mr Malkowski:** I'd like to respond specifically to the PC members who were saying they hadn't heard one complaint to their office. I'm happy that the concerns of the Ontario seniors' alliance were recognized, but you said that not one person had a complaint. We were saying that the Ontario seniors' alliance was concerned about how its participation could happen. One of the comments was talking about the Red Cross and its mechanism. I asked if there is a formal mechanism for them to allow consumer participation and they responded by saying that they did have to work on that issue. But it was interesting.

As you have talked to the public this morning, perhaps I could talk to the public and say that if there were people who had concerns, they should perhaps be contacting Mr Jim Wilson's office. Then we can really hear if he is hearing all of the concerns.

Also, another comment was made by the member for Burlington South, Mr Jackson, saying that there was a connection with the tainted blood issue. I say those are not valid comments and there is no connection between this issue and that issue. I'm happy with the comments made by Barbara Sullivan in trying to dissociate herself from those comments and that there is no connection.

My final point is, I would like to remind you that the senior population, who are the consumers, deserve their voice to be heard on how they want best to see the system improved. I think the Common Sense Revolution tries to cut and to hurt the seniors and the vulnerable people and people with disabilities, and I think that is not a commonsense philosophy, because it is hurtful.

The recent book about Mulroney being *On the Take*, I think that's just a symbol of the work with the Tory government and the Tory philosophy, and I think that's terrible.

**Mr Jackson:** We're bringing up Karl Marx now.

**Mr Wessenger:** Mulroney and Karl Marx in the same category. That's interesting.

**Mr Malkowski:** I think that is just an example of Tory work and that's not an appropriate way to work. What we want to see here is people working to have an accountable, representative system where it isn't controlled.

**Mr Sullivan:** On a point of order, Mr Chair: Could the member speak to the motion?

**Mr Malkowski:** I think it's time to hear the voice of Ontario seniors and allow the consumers who have their experience to be taken into consideration. I think we have to be accountable to get a balanced perspective from the service providers of Red Cross, VON, but also get the consumers' perspective in as well so that we satisfy the consumers. I think that's the message the seniors want us to hear from Ontario. I don't think we need to be fooled by the Tories' Common Sense Revolution and their work.

**The Vice-Chair:** Mrs O'Neill.

**Mrs O'Neill:** I had my comments in response to Mr Malkowski earlier, Mr Chair.

**The Vice-Chair:** I'd like to go to Mr O'Connor, but he wants me to follow rotation, so I guess I should go to—

**Mr Jim Wilson:** That was his request. I like the old system of put your bloody hand up.

**The Vice-Chair:** Mr O'Connor, you're next on the list.

**Mr O'Connor:** I guess the reality is that as we've gone through these committee hearings, we usually have followed rotation. I thought it might be easier in the matter of rotation to deal with it, but it's quite acceptable. I would like to deal with the clause.

**The Vice-Chair:** The Chair wishes to respond. I have recorded all the names and you'll find there's a good rotation except on occasion, mostly with the government party which has had several speakers in a row, but it's because they put their hands up. I have the proof here and I can give it to you if you wish after all this. Anyway, I'm sorry it's so long that you've had to wait to speak today.

**Mr O'Connor:** I do appreciate that, Mr Chair. I'm certainly not about to go back to Hansard and check the time of some of the speeches, because I don't think we need to do that. Thank you, Mr Chair.

I want to deal with the clause before us.

**Mrs Sullivan:** That would be a—

**Mr O'Connor:** Unfortunately, it's hard to do that over the heckles from my colleagues, because they haven't dealt with that. The matter before us today is clause-by-clause of Bill 173, and the fact of the matter is that the clause and motion before us deal with what they feel is something that's going to eliminate the Red Cross from the provision of services. That's their feeling. They've pointed out on several occasions that we heard from the Red Cross in Toronto, we heard from them in Thunder Bay and right across the province through our hearings, and in fact we did. I guess if there's maybe some criticism of some of the consumer groups out there that we didn't hear from, it's that they should have done the same thing. They should have come out again and

again and said for the million people whom they represent across this country that they want to see this type of evolution take place.

**Mrs Sullivan:** Who does the Red Cross work for? Consumers.

**Mr O'Connor:** The point is, change is always a difficult thing. Change is something that isn't easy. You know, we have to at some point start to re-examine the mandates. I don't doubt for a moment that if long-term care is an essential role that the Red Cross wants to continue to play into the future that they aren't going to go back to Geneva and say, "We want to see an accountability mechanism in place to meet the demands of the consumers in Ontario." The consumers of Ontario said through a consultation process, "We want to have some local accountability." The Red Cross doesn't have that ability.

1120

**Mr Jim Wilson:** Let's get rid of the UN in New York.

**Mr O'Connor:** The fact of the matter is that I don't believe—

**Mr Jim Wilson:** Let's get rid of the UN, make community boards—

**The Vice-Chair:** Please. Mr Wilson, I call you to order.

**Mr Jim Wilson:** Geneva, a neutral country, a city of the world—

**The Vice-Chair:** Mr O'Connor has the floor and we wish to hear him speak. Proceed, Mr O'Connor.

**Mr O'Connor:** Thank you, Mr Chair. The reality is that the consumers, the seniors in Ontario, don't have access to that wonderful organization through a policy process. They don't have a direct element that can go to the governing body. The makeup—

**Mrs Sullivan:** What are you talking about?

*Interjections.*

**The Vice-Chair:** Order.

**Mr O'Connor:** What we heard from the Red Cross was that they weren't able to be part of the process because it wasn't within their incorporation papers.

**Mrs Sullivan:** Because of your rule.

**Mr O'Connor:** I don't want to minimize the credibility of the Red Cross that my colleagues want to by saying that they aren't going to change and, as difficult as change is, re-examine the role that they do play in long-term care within our community. I believe that if they are going to continue, they will find that flexibility that is necessary, that will allow them to be more responsive to the consumers.

We heard a lot of concern about the volunteers, because in all of the long-term care delivery in our community there is a very strong network of volunteers. Not for one moment is there anyone on the government side who doesn't recognize the value of these volunteers. Not for one moment. In fact, I think it really does a disservice when you start painting with a broad stroke the elimination of all these volunteers that we're hearing being talked about. The fact of the matter is, the volun-

teers volunteer because they enjoy adding that value to the community. They play a very important, fundamental role in long-term care delivery in our communities, and nowhere in this legislation does that try to preclude that very important role of volunteers. In fact, we are going through a clause-by-clause process that I see a lot of strengthening going on, strengthening for the needs of those seniors, the consumers.

This was all about the consumers, and we heard from a ton of providers. There's no doubt about it. I guess a fallacy maybe could be pointed out that this is going to destroy everything. The reality is there's a lot of strengths out there. Let's build on those strengths. Let's take the strengths that are out there.

**Mrs Sullivan:** Instead of throwing them away.

**Mr O'Connor:** Let's take the community response, the consumers who want to see a change that's going to be more integrated. Let's be a little bit more inclusive and now include some disabled. Let's be more inclusive to all the community.

Now, if there are problems that my colleagues have because there are exclusive boards that my consumers, my seniors in my community, don't have access to—

**Mr Jim Wilson:** Name one.

**Mr O'Connor:** If they've got a problem with that, then—you know, it's amazing when you think of the versions that are being put forward by the opposition: brokerage, confederation. They've got all kinds of wonderful names for it. If I was to consider for a minute the type of involvement that is necessary and try to amalgamate it into what they see, let's name—how many different agencies are there here in Metropolitan Toronto? At least two dozen with home care delivery, with a budget of \$100 million. Try to get a consumer representative board that is going to acknowledge all the services and do it in a brokerage or a federated model. Why, we would end up with a board the size of the Parliament here. We'd have to rent out the Legislative Assembly.

**Mrs Sullivan:** Actually, we'd have to have a whole bunch of consumers on it, wouldn't we?

**Mr O'Connor:** We would have to rent out a board the size of the Legislative Assembly to try to allow them a chance to have some input into the process. Where can you hear from the consumers in some huge bureaucracy like that? If there's something that the government heard—

**Mrs Sullivan:** You don't know what you're talking about.

**Mr O'Connor:** —when we went out through a public consultation process, and we heard from 75,000 seniors, it was that they want it to be brought down closer to the community: "We want to have more community involvement." The seniors' alliance came here before us and said it's important the seniors have a voice in what is being played for them.

**Mrs Sullivan:** You're darned right. Nobody disagrees with that.

**Mr O'Connor:** They want to have a say in the service that's going to be provided from now and into the future. Yes, the changes that are included in this legisla-

tion are going to be around for a long time. Let's make no doubt about it. These are changes that are going to affect the long-term care delivery in this province for a long time, and no one can deny that there has been the need for this change.

We have said for over a decade—the Tories heard it when they were in government, the Liberals heard it—that there needs to be a change. Now, all of a sudden, as the changes are coming about and as we respond to the direct concerns brought to us by the consumers, they're saying: "It's too awkward for us. We don't know how to access this. We don't know whether we have the VON in our community. We don't know whether it's the Red Cross we're supposed to turn to." The doctor doesn't know whether they should be phoning the home care program run by a regional municipality. Excuse me, but they've moved out of a regional municipality. Now they're not even covered by that program any more. They don't know where to turn to.

They need to have something that's going to respond to the needs of the consumer right in their community, and what do we have? We have everyone saying there's really nothing wrong with the old program. We can continue on as long as we want and let's come up with a brokerage model that is going to pull together the board from the VON, the board from—well, here in Toronto, there are over two dozen. We're going to end up with a board with over two dozen different service providers coming together. That's going to be more responsive? I don't think so. I don't think it is going to serve the consumers well to have that type of a model.

To go and try to put an exception through this clause that says, "Let's make exemptions for federal corporations because we'll have better access that way," I don't believe for a moment that this is going to happen.

I certainly wouldn't recommend to any of my colleagues that we support something like this, because I find this quite ludicrous. Unfortunately, what we have heard through this consultation is never enough from the consumers. When we do hear from a body that represents the consumers, over a million seniors, what do we hear? We heard: "They did a flawed study; we don't really like what you said," and then personally name the head of the presenters who came before us, and I found that quite repulsive.

Hopefully, we can keep to the high road here and deal with the facts before us. The facts before us are that there needs to be reform take place, and that's what this is about. This reform is one that is to be built upon the strengths, and while there have been solutions in the past, while there has been some networking starting to evolve, it certainly didn't start to evolve with the lack of legislation out there; it was because there was legislation under way. All of a sudden, groups come together, and I am encouraged by groups like CHATS that came before us from York region. I am encouraged that they are coming together to be part of that process.

I am sure that when we get to the end of this we're going to see a better long-term care delivery mechanism through the multiservice agencies. With that, I'll conclude my remarks.

**Mr Jim Wilson:** That was a very interesting set of remarks from Mr O'Connor. It's interesting that he somehow thinks it'll be awkward to get the two dozen or so agencies together in a partnership model, in a federated model, to help better coordinate the system in Metro Toronto.

In his example, the 200 would be an unwieldy board, but under this bill the government is creating 20 multiservice agency boards in Metro Toronto, each with, I don't know, 15 or 20 members. Let me see, that would be 20 times 20, 400 people now to run and coordinate services in Metro Toronto just at the board level.

**Mr Jackson:** Four thousand.

**Mr Jim Wilson:** No, it's 400. I did take university math, I recall.

Please think of your own arguments in that sense. It's a problem to get together 200 but, in the name of big government, bigger is better: "We need 400 to replace the two dozen because we can't trust those two dozen to continue to provide the 75 years of service they've been providing to the community." The NDP came along and in four short years they want to remake the province in their own image.

1130

Mr Malkowski spoke about the Common Sense Revolution. Again, as I have to do from time to time in these committee hearings, I would remind him that health care is a top priority of the Mike Harris government, that we're the only party out there now promising and committing, and we've done the numbers to seal the health care budget and to make sure that any saving derived in the system—

**Mrs Sullivan:** On a point of order, Mr Chairman: Could the member speak to the point, please?

**Mr Jim Wilson:** I am speaking to Mr Malkowski's comments about the Common Sense Revolution, which he felt was pertinent, and it is pertinent to health care in the province.

I can't help it if the other parties are jealous of the fact that we brought out a commonsense policy that the people of Ontario agree with in overwhelming numbers, and that the NDP policy is to re-engineer the province in its own social image, as we see in this bill, and the Liberals are mute on health care policy with respect to how they will fund and how they will ensure that seniors have the services and that the people of Ontario will have health care services, the full spectrum of health care services, when they need those services.

People are extremely worried, and it's part of the debate here today, that with the monkeying around and the dollars you're going to be funnelling to administration and to takeover and to annihilation of community services, valuable dollars in the health care system are being absorbed into starting up this MSA process and money will not be available to provide the services to people when they need those services.

**Mrs Sullivan:** On a point of order, Mr Chairman: The amendment that's before the committee is to redefine an agency to include a corporation that's incorporated under federal laws and that has operated "without the purpose

of gain." Perhaps the member could speak to that amendment.

**Mr Jim Wilson:** It is, you will know, in Robert's rules and Beauchesne and everybody else, quite appropriate to speak and respond to debate which has been raised surrounding the amendment on the table, which is what I am doing. It's perfectly within order, and I appreciate your recognizing that, Mr Chair, because you've in no way cut me off, which is your prerogative and yours alone.

I do want to read one thing about volunteers. It was provided by the three groups: the Red Cross Society, Ontario division, the St Elizabeth Visiting Nurses' Association of Ontario, and the Victorian Order of Nurses (Ontario). It's in response to the Price Waterhouse study that was sponsored by the Seniors Citizens' Consumer Alliance for Long-Term Care. The section is entitled "The Loss of Volunteers." It is extremely important. It is what we've been talking about here. It says:

"In looking at the long-term cost of the amalgamated MSA, Ontario can learn from the experience of other jurisdictions, such as Quebec, with their local community service centres," which I spoke about yesterday in debate.

"Regarding the CLSCs, the Quebec government task force report on health promotion, Objective: A Health Concept in Quebec, stated, 'Furthermore, the government has often been reproached for killing the volunteer movement by systematically paying people in the community to do the work they formerly did without pay.' The report stated that charities previously providing service in Quebec have 'progressively disappeared,' and the overall wage cost for services increased.

"VON has 5,000 volunteers and Red Cross has 10,000 volunteers in home support programs. The Human Services Alliance, which includes St Elizabeth's, has calculated a value of \$10 million per year in volunteer support in time given for the archdiocese of Toronto alone."

The Human Services Alliance also includes such groups as St Joseph's Health Centre, Saint Michael's Halfway Homes, Villa Colombo, which we heard from, the Catholic Health Association of Ontario, children's aids, which we heard from, and Catholic Charities of the Archdiocese of Toronto, many of those who spoke to our committee, and it asked the question, "Has the government calculated the financial cost to the health care system if these volunteers and community members do not transfer their loyalty to the MSA from VON, Red Cross"—which is pertinent to the motion—"and Saint Elizabeth?"

To date, the legislative hearings have heard from any number of community provider groups expressing concern about the retention of volunteers with the shift to multiservice agencies; they have heard the same from volunteers. This loss will be a high-cost add-on to the system.

Again, the government, in dismissing this motion, in not supporting this motion—and there is an identical motion to come up from the PC Party—just ignores the arguments put forward by these agencies and by volun-

teers. We've tried to make our points in as forceful, emotional and factual a way as possible. Unfortunately, the government is not listening to these valued agencies in our society and is hell-bent on putting them out of business. I'm sure to the day they go to their graves they'll deny they did it, but I can tell you, you're doing it, you're putting them out of business. If you won't accept this series of amendments in section 2, then please reconsider the 80-20 rule, which, if you got rid of that, would help to alleviate a lot of the stress you're putting on the community service sector with this legislation.

**The Vice-Chair:** Ms Sullivan, did you wish to speak?

**Mrs Sullivan:** Yes. In conclusion, with respect to the amendment I have put forward, I think it goes without saying that our party is highly disappointed and deeply discouraged by the government's intransigence in not accepting and not recognizing the value and the expertise and the service which has been provided to people in Ontario for close to a century by Red Cross in home care and homemaking services.

This amendment would have ensured that Red Cross would have been part of a new long-term care system. What the government is saying is that Red Cross has no place, and we deeply, deeply regret that. I believe it's clear the government does not intend to change its view. I suppose the only thing I can say to people in Ontario who have been served by highly qualified volunteers and employees of Red Cross is that it's a loss to everyone in Ontario.

**Mrs O'Neill:** Except for lawyers.

**Mr O'Connor:** I want to address the point my colleague Mr Wilson raised. When he refers to the CLSCs from Quebec and the report done back in the 1980s, the reality is that those were boards that included professional groups in the process. This isn't the intention at all. Of course, here we've no intention of paying the MSA board members, and they are to be volunteers, which is a different principle. I guess that's the closest reaction he can come up with to that as a model. It's very loose in terms of trying to compare the two, because the two don't compare that well together. I just wanted to make that point.

1140

**The Vice-Chair:** The Liberal motion to amend subsection 2(1) of the bill is before you.

**Mrs Sullivan:** Recorded vote.

**The Vice-Chair:** All in favour of the motion?

**Ayes**

Curling, Jackson, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Carter, Malkowski, Martin, O'Connor, Rizzo, Wessenger.

**The Vice-Chair:** The motion is lost.

The next is a PC motion regarding the same matter.

**Mr Jim Wilson:** Mr Chairman, as the identical Liberal motion was defeated, I gather it would be redundant and probably out of order to pursue this motion.

**The Vice-Chair:** Yes. The next is a PC motion to amend subsection 2(1) of the bill.

**Mr Jim Wilson:** Is the one you're referring to the federated multiservice board, Mr Chairman? We have a couple.

**The Vice-Chair:** The Canadian Red Cross; to add (c.1).

**Mr Jim Wilson:** I move that the definition of "agency" in subsection 2(1) of the bill be amended by adding the following clause:

"(c.1) the Canadian Red Cross Society."

In discussions with legal counsel, it was felt that if the government were to reject the previous motions put forward by the Liberal Party and one by the PCs with respect to incorporation, and if the government won't modify some of its makeup of the board of the MSA, and if the government won't move on the 80-20 rule, which we're hearing it won't, perhaps the most direct and simplest way to ensure that the Red Cross is able to continue in existence in Ontario—it will be in every other province, but it won't be in Ontario if this bill goes through—to ensure that it can continue to do its good work, it was suggested and agreed to by myself, on behalf of my caucus colleagues, that we simply add the words "the Canadian Red Cross Society" to this section, which would allow it to become an agency as described under the act and, subsequently, possibly a multiservice agency as described under the act, as we can't get the government to move on its incorporation rules in clauses (a) and (b) of this section.

They do allow a municipality and a board of health under certain conditions to become MSAs. They will allow, as the wording of the bill is, "a council of a band" or "a first nation," as I think subsequent amendments will read in this section, to compete to become an MSA. However, we want to add also the Canadian Red Cross Society so that it can continue, so that it may in fact become an MSA.

If the government wants to achieve its objectives for this legislation, why tear down existing agencies? Why not in this case allow the Canadian Red Cross to prove to you that it can become an MSA? It's a big player in the system now in Ontario, which you know undeniably is the case. You can then on a government-to-Red-Cross basis negotiate perhaps some change in representation. If you want more consumers, if you want to make sure—which is the case now, by the way: that people may participate, may volunteer, may go in and talk to the Canadian Red Cross any time.

But if you want to do that, you've got four years in this bill to get these MSAs up and running and delivering services. During that time, if you put the Canadian Red Cross in now, you can then go back and talk to it and you won't have put it out of the business in the meantime and you can work with it and maybe come up with some bylaw changes, if the Red Cross can do that, to help meet your definition of an MSA.

I think it's a reasonable approach. It puts them on equal footing with municipalities and boards of health. We will also, I hope people will note, in the later amend-

ments deal with a bias against establishing municipalities and boards of health as MSAs; we will be asking that that clause be deleted. But for now we ask that the Canadian Red Cross be specifically mentioned in this part of the bill so that it will continue to exist in Ontario.

**Mr Wessinger:** I'd just like to point out that the Canadian Red Cross Society is a federally incorporated agency, and the same arguments we had in the previous resolution would apply. I suggest we should just vote on the motion.

**Mr Tony Martin (Sault Ste Marie):** I just want to put a couple of thoughts on the record in light of the discussion that's gone on for the last almost two hours. It won't be long.

For me, this bill is about integrating services. It's not about integrating agencies or anything else, it's about integrating services, it's about improving services, and it's about improving access to those improved services across the province. We're putting significantly more money into the system as we move in that direction.

We have some choices: We can either continue to prop up the existing agencies, which have done good work—nobody is saying they haven't—so that a whole pile of the new money going in goes to administration as opposed to the actual services to people that we want to see improved, or we can integrate the services and set up one administrative structure that is as cost-effective as we can make it so we can in fact do what I've said we're trying to do here.

There's the accusation that instead of doing this what we're in fact doing is a concerted effort to wipe out some charitable organizations in this province, and that's not the case. Change is difficult and it affects groups differently. Certainly, in this instance I don't think we're pretending for a minute that what we're doing here will not significantly affect some of the organizations out there in our communities that are held in great esteem by all of us, cause them to rethink their mandate and their mission and hopefully cause them to return to the reason for getting into this business in the first place, which was to serve people.

If, with a gathering of people in the community and some of the work we've done around the question of how we more effectively spend the new money in the interests of people in need of long-term care in this province, it is a new, more coordinated, integrated organization that spends more money in the trenches than it does in the offices of the organization, then that's where we're going.

Specifically, on the question of the Red Cross, certainly it has done good work in our communities and continues to do good work. I've sat in my office and talked with some representatives of that association over the last couple of months and struggled with them re this whole question. I shared with them, however, that my understanding of Red Cross, my first coming to know Red Cross, was certainly not under the banner of it delivering long-term care in my community; I came to know Red Cross because of the very valuable and important work it does in the area of blood and the very important and valuable work it does across the world in responding to crises and emergencies of various sorts. We watch

television at night sometimes and see the Red Cross in some areas of our world where none of us would venture to go because of war and famine and things going on.

To suggest for a minute that the changes we are making in Ontario to our long-term care will result in the disappearance of Red Cross from the face of the earth or from the fabric of the social service or human service or health service delivery in this province is just not true. Yes, the Red Cross will be impacted seriously by what we do re this bill. However, I'm convinced, as a person who has parents who are now dependent on these services and as a person who will, in the not-too-distant future, depend on them himself, that this is in the best interests of the consumers, of those who are in need of long-term care and will continue to be in need of long-term care in this province.

**Mr Jim Wilson:** I appreciate and respect the comments by Mr Martin from the government side. I don't agree with much of what has been put forward. I certainly want to make sure that people understand that, yes, Mr Martin is correct, the Red Cross will continue with its work in the area of blood, at least for now. Mr Jackson did make the point that there is some uncertainty in that regard, with the Krever inquiry going on now. However, I do not know what the outcome of that will be; none of us does.

But the Red Cross, along with the other agencies we've frequently mentioned, tell us, and I have no reason to doubt them, that they will be out of the business of providing homemaking services and these community services listed in the bill that they're currently providing, which range from a number of services.

**1150**

I grant you, if they feel it's worthwhile to keep some staff around on that side of their ledger apart from the blood side to run an adult day program, because we know adult day programs for the purposes of funding and contracting are exempt from the 80-20 rule, they may want to still be in that business. But they're telling us they probably won't, because it's not worth their while to keep an administrative structure on that side to only deliver a very minute portion of the community services they're currently involved in, because that's what you're rendering them to. You're putting them out to pasture to compete with the existing agencies for a very small portion of the service sector.

If you want to talk about cost, it is not cost-effective then for Red Cross or VON or anyone else to stay in existence on that side of the ledger just to provide a minute portion of services. That's the point. Therefore, on a cost-effective basis, Red Cross and VON and that will dissolve those divisions, and that's what they've said very clearly. They cannot justify to their community-based boards, in the case of VON and that, those costs to simply provide such a small portion of the market.

Again, in my part of the province and Mr Wessenger's part of the province, Dan Waters's part of the province, Al McLean's part of the province, Simcoe county, 97% of homemaking services are delivered by the Red Cross. They will not be in business in Simcoe county after the MSA is formed, because you're expropriating those

services and putting them under the MSA. They've made that very, very clear. To only be around to serve a very small portion doesn't make sense for them to keep administrative structures for that.

The other point I wanted to make on this is, Mr Wessenger said that for the same reasons of incorporation they can't support this amendment. However, I would say to him that what this section does is very clearly talk in two parts about a corporation under the Corporations Act, Ontario, and cooperatives. An MSA can be a cooperative model.

A municipality I don't think is incorporated federally, Mr Wessenger. I don't think a board of health is incorporated federally. Therefore, I'm trying with this motion to put the Canadian Red Cross on the same basis that in the future it may become an MSA on the same basis that a municipality or board of health may.

So you can't tell me that (a) and (b) have anything to do with what we're talking about now. You specifically had this definition of "agency" in the bill to provide for such things as the exceptions to those that aren't incorporated now under either part (a) or (b). So you have to list municipalities separately, you have to list boards of health separately, and I'm asking you now to list the Canadian Red Cross, because it is the group that has come forward and said, "Because of the structure here and the incorporation rules contained therein, we need a separate exemption if we're to continue and if we're to participate in your own MSA model."

I can see in Simcoe county, with the seven major players we have, Mr Wessenger, who are all non-profit, by the way, with the exception of a bit, 3% of the service provided by Para-Med and maybe one or two other private agencies, the agencies together, if allowed to cooperate together and allowed to form partnerships, may very well end up, with one of the big players like the Red Cross, wanting to be the MSA there.

Your bill would prohibit that. Your bill says, "No, we've got to reinvent the wheel totally," and I think that in the name of allowing communities this empowerment that Ms Carter and Mr O'Connor and everybody else seem to talk about but refuse to do anything about, just talk about it, we should allow the Red Cross in the future to become an MSA, and therefore it needs this exemption in the act under the definition of "agency."

**The Vice-Chair:** The parliamentary assistant wishes to clarify a matter.

**Mr Wessenger:** Yes, I'm just going to ask legal counsel to set out the legal aspects of this concerning the Red Cross.

**Ms Gail Czukar:** I just wanted to clarify that the reason the other agencies such as boards of health and municipalities are specifically listed is because they don't fit the definition of an organization that's incorporated under the Corporations Act or Co-operative Corporations Act. The Canadian Red Cross Society, as a federally incorporated body, cannot be an exception because it's still subject to federal corporations law, and as a matter of corporate law, provincial legislation which impinges on the corporation's corporateness and ability to control

its own affairs doesn't apply to a federal corporation. So the provisions in our bill that would be consequences of particular kinds of breaches of the act simply wouldn't apply once the Red Cross, as a federal corporation, was an agency and was operating. So we would lose the accountability that we would like to have, in addition to the fact that we couldn't impose our governance requirements under section 11 and so on on the Red Cross because it is a federal corporation.

**Mr Jim Wilson:** In response to that, I will accept your legal argument of why you can't accept this amendment. What I don't accept is the lack of political will on behalf of this government to allow MSAs to adjust this bill in whatever way is recommended by legal counsel to ensure that the Red Cross can become part of the MSA structure. Now, do you have the will to allow that to happen or are you absolutely determined to drive the Red Cross out of any participation in the MSA structure that you're formulating?

**Mr Wessenger:** To answer that question, we are adamant with respect to the MSA structure having an integrated, functional system. As you may have recalled, there may be various methods of governance with respect to an MSA. There was a submission to this committee suggesting that the cooperative method could be used as a method to allow existing provider agencies to have a role in governance of an agency. That was a legally permitted model. But certainly as far as the functional integration of the system, that's not a negotiable issue as far as the government is concerned.

**The Vice-Chair:** I had one additional speaker.

**Mr Jim Wilson:** Briefly in response to that, Mr Chair—

**The Vice-Chair:** Mr Wilson.

**Mr Jim Wilson:** My belief is, where there's a will, there's a way. You've forthrightly said there is no will on behalf of the government to make adjustments for the Canadian Red Cross to participate in your MSA structure. And they've ruled out the cooperative model.

**Mr Wessenger:** That is the only potential model that was brought to our attention that could fit within the scheme of the act.

**The Vice-Chair:** We had one additional speaker: Mr Malkowski.

**Mr Malkowski:** I think it's important to understand when we're looking at the MSA structure that if they decide to perhaps purchase services from the Red Cross, this isn't prohibiting them from doing that. I mean, they are a valued service provider. It would be up to the structure of the MSA to define its needs depending on what the local community decides.

As well, what is important is accountability, and we have to be accountable to the local community. But I think we have to also listen carefully to the concerns raised, again, by the Ontario seniors' alliance. It's very important for them to have a formal mechanism of involvement to feel satisfied with the services, and perhaps the Canadian Red Cross could think about that in terms of when we look at the establishment of the MSAs.

**Mr Wessenger:** I'd just like to indicate that there is

certainly a level of flexibility, and I'd like to make it clear that it's possible the Red Cross may continue to play some role with respect to the long-term care area. I wouldn't like to say, because each local community is planning its own proposals—for instance, it may be that the Red Cross could play a role with respect to training, for instance, of homemakers.

Even though they wouldn't be involved in the administration of employing them, they could be involved, for instance, in some specialized services that they may develop and they may continue to play a role. That's going to be up to the Red Cross, what role they want to play, and up to the local communities how they see they can work with such agencies.

The same with VON or any existing agency; they can develop new mission statements that can still provide for them a role within the whole question of long-term care.

**The Vice-Chair:** Thank you. The PC motion to amend subsection 2(1) by adding clause (c.1).

**Mr Jim Wilson:** Recorded vote.

**The Vice-Chair:** Recorded vote. All those in favour of the motion?

**Ayes**

Jackson, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Carter, Malkowski, Martin, O'Connor, Rizzo, Wessenger.

**The Vice-Chair:** Motion lost. The committee stands adjourned until 2 this afternoon.

*The committee recessed from 1201 to 1414.*

**The Acting Chair (Mr Alvin Curling):** We'll resume the clause-by-clause consideration of Bill 173. I think when we left off the PCs had an amendment before us.

**Mr Jim Wilson:** I move that subsection 2(1) of the bill be amended by adding the following definition:

"'federated multiservice board' means a board established under section 11."

I don't think it would be appropriate to belabour the debate at this point about a federated multiservice board, which is the federated model being put forward by the PC caucus, given that an earlier attempt to change a definition certainly failed and it was made very clear that—sorry, am I on the wrong motion?

**The Acting Chair:** Yes, I was just thinking about that. Maybe in sequence it's the Liberal in regard to the case management. Would you want to move that, Mrs Sullivan?

**Mrs Sullivan:** I move that subsection 2(1) of the bill be amended by adding the following definition:

"'case management' includes,

"(a) the assessment of the needs of a person applying to receive community services and/or the evaluation and monitoring of the needs of persons receiving community services; and

"(b) the provision of community services directly to individuals and the coordinating of the provision of

community services to the individual by health care professionals and other service providers.”

**The Acting Chair:** You'll be speaking to that, Mrs Sullivan?

**Mrs Sullivan:** I'll be speaking on it as soon as I can find it. This amendment is one that came out of quite deep concerns through the entire hearing process with respect to how people are dealt with once they seek long-term care services.

It was very clear that in a scenario where we have an integrated and single-point access for either information about services available that a person would require with respect to the eligibility for services or with respect to the actual access to delivery of services, the professional services that were included in the bill related to nursing services, occupational therapy, physiotherapy, social work, speech-language pathology and dietetics, the very specialized nature of case management itself, which is involved in intake services, in assessment and coordination of service delivery, had been left out of the bill.

One of the things that we were concerned about and that people who appeared before the committee were concerned about was that without case management being recognized ultimately as a professional service, then indeed the person could be left without linkages into the system, without actual emphasis on coordination of services in an appropriate way, without full assurance that not only the social needs but also the clinical needs of the individual were met through an appropriate assessment and coordination of those services.

In consequence, in the bill we will be including, under subsection 2(7), case management as a professional service. The definition that we have included here of “case management” is the definition, slightly adapted, which is being used for case management in mental health reform. The work of the case manager in either this circumstance or in the mental health scenario is comparable. Indeed, the case management association put forward words that are also included in and reflected in this definition, and we feel that it pretty much sums up the role of a case manager.

The other issue that came very much to the fore was the concern about the risk intervention/crisis intervention situation. We heard some horrific tales. Frankly, after some of the tales that we heard I got some autopsy reports and looked at what the situation had been in those circumstances. They probably or possibly could have been avoided with the intervention of a case manager who would have been able to maintain ongoing contact with the individual about whom there was concern, rather than having a person here, a person there and so on.

We feel that this is an important amendment, that the recognition of case management is quite key to the assurance that people who are seeking care and services and information will be able to find them through an MSA in a logical way and with the expertise provided through a case management system.

I'm urging the government to accept this new definition of “case management,” understanding that in 2(7)

we're asking that case management also be included as a professional service.

1420

**Mr Wessenger:** We have a problem with this amendment for two reasons. The first reason is that we don't believe the definition is accurate in that the provision of community services directly to individuals is, in our opinion, not part of case management services. So that's a problem with respect to how it's defined.

The second concern is that certain adults, particularly those with physical disabilities, take exception to the use of the term “case management,” and we in effect have included all the functions of case management under section 20, and we feel that is adequate.

The reason of course for defining “case management” would be if you're going to refer to case management in later provisions of the act, as Ms Sullivan said, if you're going to list it as a professional service, and we don't think it should be listed as a professional service.

**Mrs Sullivan:** If I could respond to that, indeed the definition is accurate in that a case manager may ordinarily be a social worker or a nurse who, as part of the services that they would provide, may well do either the social work or the nursing services. To exclude that direct provision by a case manager is an incorrect definition of the work of a case manager.

I'm interested in the parliamentary assistant's concern with respect to some representatives of the disabled community who do not want case management. I believe that there is and ought to be provision that is accounted for, probably in Bill 101 and less so in this bill, that would enable the physically disabled to manage their own services in such a way that a case manager would not be required in every circumstance.

I also point out to you that nursing services would not be required in every long-term care situation; that occupational therapy services, physiotherapy services, social work services, speech-language pathology and dietetics would not be required in every circumstance for every client who comes to the MSA. Neither would case management or the full range of the work of a case manager necessarily be required for every individual who comes forward. None the less, just as that full range of services isn't required for everyone, those professional services are included in the bill. We believe that case management also ought to be included in the bill.

**Mr Jim Wilson:** I want to speak in support of this Liberal motion. Somewhat along the lines of Mr Wessenger's line of thought, I think it actually points to a need for a definition of “case management.” Certainly we should be including the term “case management.” There's also a PC motion for subsection 2(7) to include case management in that list of professional services. We think that's absolutely essential.

I think it would be very difficult to leave section 2, the entire section, without some mention of case management. Because there is some degree of diversity with respect to the definition of “case management,” I think it's appropriate at this point that a clear—and this is very well worded and clear—definition of “case management”

be included in the bill so that in subsection 2(7), hoping that you'll accept the PC and Liberal motions to include case management in the list of professional services, people know when reading the bill what exactly we mean by "case management."

I really didn't follow your first line of reasoning with respect to rejecting this idea. Perhaps you'd like to repeat it.

**Mr Wessenger:** The first aspect: Ms Sullivan said that case managers will in effect sometimes provide service, and I think that's a fair comment, that people who are presently in the role of case managers probably in the restructured MSA will in fact be providing services other than just case management. But if you look at the type of services, case management generally relates to assessing the needs of an individual, monitoring, evaluating, reassessing and deciding the appropriate mix of services that person should receive, in conjunction with working with individuals, obviously, and taking into account their wishes.

When you're defining services, you're confusing it by saying it includes provision of service, because that means that in effect case management includes everything under the whole act, because every service could be part of case management. I think that's too broad a definition, because that means anything from providing Meals on Wheels to providing occupational therapy. That's really my concern on the definition. I would think the definition was probably quite adequate if you took out the words "the provision of community services directly to individuals and." The rest of the definition probably is fairly accurate.

**Mrs Sullivan:** I'm prepared to make that amendment if the government's willing to accept the definition.

**Mr Wessenger:** I think the second position is we're advised that it hasn't been a policy to define it in the act or to refer to it in the act but to deal with it by setting out the function in section 20.

**Mr Jim Wilson:** That very aversion the ministry seems to have to case managers is outlined in the brief that was presented to this committee by the Ontario Home Care Case Managers' Association. I want to read from page 3 of that brief, where it says:

"Case management has been misunderstood and undervalued. The essential core functions, the skills, knowledge and experience of case managers continue to receive lipservice from the ministry. Ministry staff acknowledge the issue and assure case managers that the ministry acknowledges the vital service of this core element of the community delivery system, yet there remains a reluctance to identify case management in the legislation.

Key functions of case management are holistic assessment, service planning and coordination, resource management, reassessment, alternative planning for changing needs or discontinuation of service. These functions provided by present home care case managers ensure accountability and consistency, and reduced fragmentation and inappropriate service utilization."

I think that any parliamentary assistant to the Minister

of Health would have a very difficult time wanting to continue with his argument that case management shouldn't be defined and indeed included in this bill when they're ready, able, willing and already helping you to achieve your goals in long-term care and should be very much part of the reform system. If you don't like the wording of the Liberal motion, Mrs Sullivan's already indicated that she's willing to show some degree of flexibility there. Do you have any other suggestions of why you don't like the wording, and we'll work with you on it.

**Mr Wessenger:** If I might just respond, I think the concern is often we have perceptions people have from the use of language. I think that's what we're dealing with here, a perception of the use of the phrase "case management."

As you know, we had a discussion at noon today with members of the first nations and language was very important to them with respect to how they were described in the bill. The same thing could be said for those people who are receiving services. It's the idea that people are receiving services. They don't want to think of themselves as a case or they don't want to think of themselves as being managed. That's the aspect that consumers find offensive, this idea that they are a case and they're going to be managed. It's a perception. They want to think that they're individuals participating in their own plan of service.

**Mr Jim Wilson:** This is a profession that has a title, whether you like it or not and whether those consumers who are making that argument like it or not. These people provide valuable services. They don't go around referring to their clients as cases, person to person. It would be much like our constituency cases. We've got them, but we call them by their names when we go to their homes and speak to them on the phone.

What you're doing here is simply recognizing a profession. You list other professions, like nursing and occupational therapy and physiotherapy, and to me it's important that case managers be recognized as a profession and be part of long-term care reform. And I don't think, because the name of their profession or their job title is case management, that they necessarily go into people's homes and call them cases in management.

1430

**Mr Wessenger:** It is a question of perception, I agree with you, because the case managers are doing an excellent job of respecting people's wishes and getting them to be involved. But language sometimes has an impact, and it's the concern about the language rather than anything else that is the reason, respecting consumers' representations that they don't like to be thought of in that concept. That's the reason for rejecting the definition.

**Mr Jim Wilson:** A very interesting argument, not one I am particularly familiar with.

**Mrs Sullivan:** Or have contemplated or heard before.

**Mr Jim Wilson:** Yes. It may take me a moment to digest this one, because that would mean we should just have generic names for all professions, I suppose, in case

somebody might get labelled something they don't want to be labelled.

I don't see it as a language issue, as you specify. I see it as the title of an existing profession that needs to be recognized in this round of reform or you're leaving in jeopardy their status and leaving in question, I think, how professional case managers are to be included in the MSA structure and in the services delivered by that structure. I see a real need for it in the act. I am open to hearing your language argument again, but I must admit at this point that I don't particularly understand it.

**Mr O'Connor:** I appreciate the opportunity to speak on this issue. It certainly is one we had some representation made to the committee on. I think the important thing here is that what we've tried to do through this entire process is recognize the involvement of consumers, the consumers' right to be involved in their own decision-making to ensure that they can in fact have some direct involvement in how their—using generic words—case might be managed. I don't think they see themselves as that, as Mr Wilson pointed out. But section 20 of the bill certainly does involve the consumer to the best degree possible in developing the plan that's referred to by the agency.

Case management as we know it today is something that's provided through the home care program and reflects that delivery model in not so much the same way that we see this evolution taking place, where the consumers have more control in the entire process. Section 20 of the bill certainly reflects everything that would be included in what would be called case management. I don't think adding the words "case management" in the fashion proposed by this Liberal motion adequately reflects the role the consumer is to play in this.

The reason all this change is happening is directly a result of the consultation that pointed to more consumer involvement. We've read articles in the paper about people who are being visited by nurses because they've been sent home, where they maybe prefer to have the homemaker who was there in the past.

**Mrs Sullivan:** With a case manager, that wouldn't have happened.

**The Acting Chair:** Let Mr O'Connor finish his comment.

**Mr O'Connor:** It's not to say that the individual is going to make a decision that will affect all the care they are going to get, but they're going to be involved in the process of developing their own plan of care. The important thing is that all the elements my colleagues are referring to in terms of case management are certainly well covered off in section 20 of the bill—they're there in great detail—and if they want to make suggestions, it may be more appropriate to deal with this issue in section 20. But the primary concern here is the fact that it's the consumer who wants to be involved in this process.

**Mr Jackson:** I suspect there are several reasons why the government is resisting some of these amendments, some of which emanate almost exclusively from the deputations that were before this committee for the last several months. One reason, a punitive sort of reason, is,

"We don't want you to get credit for doing it." The second is that they probably don't want to do it because they don't believe in it, and a third reason is that they don't want to do it because they'll lose control. I suspect it's a combination of the last two, because this recommendation makes eminent sense.

Yesterday, we took most of the day to discuss how we were going to make this system more efficient, more powerful because we utilize the resources in a more effective way. There was one key phrase the government defeated yesterday that was put in both Ms Sullivan's and Mr Wilson's and my amendments, and that was the issue of coordination. That disturbed me, because I couldn't understand why the government was so scared of putting in the purpose section the word "coordination." Now, in our first opportunity to deal with something tangible about coordinating services, which is case management, we get the government running for cover.

One of the knocks put on this bill by several groups, especially some of the unions, who allegedly are good friends—at least the last we checked they were still good friends—with the government, was that it was deprofessionalizing this process, that it was utilizing an old collective bargaining trick: for the government to wrest management control by isolating and denying not the bargaining rights but some of the professional skills required to make the system work.

The analogy in my mind is with the teachers with specialist certificates. School boards try and say, "We want to hire any teacher we want." The teachers legitimately say: "We have a specialist certificate. We specialize in this. We've fought hard in collective bargaining." But the child who receives our services deserves the best teacher for that, who's qualified to do that job. When you're contract-stripping, you try and pull that away.

I think all that is being asked here is that we have a group of professional individuals who are integral to part of the process, which is to coordinate an individual's needs, which are both complex and multifaceted and change at different times during the course of their need for those services. If you understand anything about the aging population, you'll know that they change, that they're multifaceted and that they're complex. You can need certain supports in the home because you don't have access to chiropractic service, which then means you need someone else to do some other medical intervention in the home setting. All of them build on each other.

That's what case management is like, and that's why in Ontario, where we believe we have one of the best systems in North America, we achieve that, because we allow these professional groups, case managers—and my colleague Mr Wilson has quoted extensively; there's no sense for me to re-read it into the report. But the Ontario Home Care Case Managers' Association, according to our researcher to this committee, has had extensive, broad-based support from all the various elements in the system.

If the government is determined to take this quality service away, we have the right to fight for that, because we believe it's that critical to the delivery of the service in an efficient manner.

I want to bring one section, if we're going to move forward to section 20 of the bill. I've listened carefully to what the government has had to say about the language. Mr Wessinger is a lawyer and therefore language has become the key issue for him, that he would like to argue its variances. Perhaps Mr O'Connor, with his background in collective bargaining, is starting to see the light about the concerns here that we are somehow deprofessionalizing and making less effective the system of long-term care reform as it relates to this motion, with case management being embodied as a service, with expectations, as a defined role within the act.

I'll tell you, I don't trust any government to implement what's in the best interests of people if it's not in legislation. The single most important defence a citizen has is to take the law which we're passing and say, "Our services could be better developed in an MSA if we had case managers, if we could hire case managers, and if this government of Ontario would fund our MSAs so we can afford these good-quality professionals to do this service."

**1440**

If you go to section 20 of the bill, it talks about how a citizen who is receiving services participates in the revisions to their plan. You can't have somebody who has limited experience with seniors or senior support services. You can't have someone who was maybe working as a lab technician at a local hospital but because they got laid off, according to this government's approach, got hired first to work in the MSA, and now this person's in charge of doing assessments and case management reviews. We can't do this hit and miss. I'm going to remind the members of the government that the way you're transferring people, with the last-fired, first-hired approach we're going to take to the conversion of many of these agencies, you're going to have a lot of unqualified people doing certain kinds of work.

There is protection in clause 20(2)(a) of the bill, which says this shall be done with an agency, arranged by an approved agency to review any given plan, that those services should be fully developed by a competent person and that that person should work closely with the person who needs the services and wants their plan revised. We're saying that the way it's written, the government can put anybody it wants in that position, and we don't think that's good enough.

This is not a language issue, it's a collective bargaining issue, quite frankly, from where I sit, because they don't want in this collective agreement the rules that will govern an MSA. They want to be able to say, "We don't want case managers." They may be a little bit more expensive, but the truth is, we'd rather have somebody who's been doing home care to now coordinate all these complicated, complex medical interventions and, as I say, the multifaceted multiplicity of services required by an individual when they want to revise their plan.

If you're not going to approach this from this point of view—and I seriously doubt your regulations are going to cover it, because if your regulations are going to cover it, you've got nothing to fear from putting it in the language of the bill. It would be misleading in the extreme to say,

"Don't worry, we'll put it in the regs." Clearly, you want nothing to do with professional case managers assisting the MSAs across this province, and I think that's wrong.

**Mrs O'Neill:** I really did think this was one of the amendments the government would consider positively, as I listened to the government members when the case managers across this province came before us as we conducted our hearings. I'm just incredulous about what the parliamentary assistant has said. I have never heard a weaker reason for not doing something than feeding into misunderstanding, and that's what this is.

I have explained to this committee before that I've had very personal experience in this area within the last two years. My father did not know anything about case management but he certainly benefited from the experience of a case manager. I will tell this government that it also likely saved you a lot of money in his care, simply because he had somebody who took an interest, who treated him as a whole person and who got the services he needed when he needed them and discontinued them when he didn't need them. He was treated with the greatest of respect and there was nothing about "managing" him. If anything, he had a fuller and better quality of life because he had a better case manager.

The case managers of this province obviously are now going to be wiped out, and I'd like to know from Mr Wessinger—and you may laugh, you may laugh, but that's what they think.

**Mr Wessinger:** Well, if you'd make sensible statements, Ms O'Neill—

**Mrs O'Neill:** I want to know where they fit into the bill, I want to know how they're defined in the bill, and will there be a role for them in the MSA? Certainly now they don't. I've met with them in two cities in this province, in large numbers, and they don't feel they fit into Bill 173. If they do, maybe you can satisfy us all by telling us where.

**Mr Wessinger:** First of all, you should be aware that we have case managers now working in our system and case managers are not referred to anywhere in existing legislation—no definition or description. The fact that we're moving to new legislation and not defining them, the same way, is not going to make any difference with respect to the role they play or the functions they fulfil, and there's certainly no indication that we will not have case managers continuing to do these as they are presently doing.

With respect to Mr Jackson's comment saying that MSAs will be forced to hire people who are not qualified, there's a provision right in the labour bill, subsection (5), that the successor employer is not required to offer positions to persons who are not qualified to perform the services required of them. Clearly, you're not going to have a lab technician doing the job of a case manager.

**Mr Jackson:** On a point of order, Mr Chairman: I did not say that. Mr Wessinger, I didn't say that. What I said was that if it's not in the bill, they won't be required to hire that level. That's an entirely different issue. If it's in the bill and they try not to hire them, they can't do it. It's a collective bargaining issue. If you're not mentioned in

the bill, you don't have to hire that person. I'm sorry you missed my point. What you attributed to me is exactly the opposite to what I'm saying.

**Mr Wessenger:** There is a requirement in the bill under section 20 that an approved agency do all the functions of case management. What you don't do is define a class of employees as a case manager. That's true, you don't do that: You don't have case managers specifically referred to. But you do have the function clearly set out in section 20, and if an approved agency is going to perform that function, it clearly has to have people who have the qualifications of the present case managers in order to fulfil the function. The agency would be in breach of its obligations if it didn't have the people providing those services. But you don't have to define and list everybody's job description in legislation. I don't see that as necessary.

**Mr Malkowski:** I believe the motion is well intended. Obviously, it shows you're caring about the consumers, but I think it can be very patronizing in many ways. There are many disabled adults who feel that the idea of assessment is offensive. If you remember, in the SARC report the former minister of Comsoc recognized concerns that were raised by the disabled community about vocational rehab services. I believe the Liberal government raised the concern that people were talking about: how the VR councillor treated their clients. Many of the disabled clients identified a problem, and I think this is a very similar point being raised, that it can be very patronizing. When we deal with assessment and things, I think this kind of motion is not appropriate and that we need to respect the dignity of people with disabilities.

Section 20 clearly defines it without talking about assessment in a patronizing way, so I would support the comments of the PA for the Minister of Health. Perhaps people, if they're unclear on what I've been saying, can re-read the recommendations from SARC. I don't support this motion.

1450

**Mrs Sullivan:** One of the things that's clear from the parliamentary assistant is that, in his view, because case management, while it exists now in certain circumstances in certain areas, isn't defined in any other legislation, therefore it isn't necessary to define it here. To my mind, that's a ludicrous statement.

We are saying that case management must and should be a mandatory service, that every multiservice agency should and must include case management as one of the services in the mandatory basket alongside other professional services such as nursing, occupational therapy etc.

The concern with respect to section 20 of this bill is that the functions that are listed here, while indeed they may be offered by a case manager in an integrated way, as they're laid out in section 20 are laid out in a linear fashion rather than an integrated fashion. The job of the case manager is to integrate, to coordinate, to ensure that evaluation and continuing monitoring is done alongside the patient, alongside the client, which is clearly included in the bill.

There is absolutely no question about there being any assault on the dignity of a client because a case manager is involved or because someone doesn't like their name. It happens to be the name of a profession. Some people might not like the name "doctor," I suppose.

**Mr Jackson:** "Politician."

**Mrs Sullivan:** Or "politician." That happens to be the name of the work they do. The work they do is to ensure the coordination of the services, working with the person to ensure that if there's any inclination or any suspicion that clinical requirements must be met, those clinical requirements are brought in only in the amount, at the right time, at the right place and in the right proportion to meet the needs of the individual. This is a person who works alongside the individual.

If you had been seriously considering the major complaint of people who were receiving services through the long-term care consultative process whenever it occurred, it was that one person was involved in this, one person was involved in that, no one knew where the case lay, no one knew what was in the records, the records were in different places.

The case manager is there to integrate those scenarios, to ensure that there is one person who works with the individual who's receiving the services, who follows that person, who ensures that the records are maintained, who ensures that the referrals are made and the follow-ups are done, that if there's any confusion, for instance, about the kind of drug that's being prescribed and how it ought to be taken, there's additional counselling associated with that. It's an integrative function. It is work. It's a professional piece of work.

If you look at section 20, indeed, many of the functions of the case manager are included in section 20. They're not presented in any way that would indicate that they have to be coordinated, that there has to be sensitivity to the needs of the client. Indeed, the coordination element is left out of this. That's the key role of the case manager. Your functions—it's not there.

**Mr O'Connor:** Case management, the way you define it, is not there; that's why it should be part of the MSA. The MSA will pull together, for example, in Metro—

**Mr Jim Wilson:** Oh no.

**Mrs Sullivan:** Just a minute. You don't understand this whole issue. You do not understand this whole issue. This is a very important issue.

*Interjections.*

**The Acting Chair:** Order. Mrs Sullivan is on the floor.

**Mrs Sullivan:** It's very important. Section 20 does not define the role of a case manager. We believe very strongly that a case manager should be included as a professional service, that people will not have the appropriate services they have been asking for, and indeed demanding, for many, many years, since long-term care reform was first contemplated and the issues discussed.

This is one of the central questions and one of the central demands that consumers have been making. In my view, the government probably is leaving this particular

issue out of the list because it doesn't want to pay for a service that it's intending to pretend that it's including but in fact isn't including. This is a money issue, and the government is saying, "We're not going to pay to give people the service that they want and that they've asked for."

**Mr Jim Wilson:** Very briefly, I just want to make it clear that the discussion on this side of the table has been quite accurate in terms of case management as a profession. It's also the name of the function that's carried out by professional case managers, social workers at times, nurses at times.

I remember visiting our VON in Simcoe county recently, the Collingwood branch, and meeting with the case managers. If one simply takes a half-hour with them, one is amazed at the amount of work they do and the amount of coordination they add to the system. As I said earlier, it's very difficult to understand in any way why you would want to shoot them out of the system now or, if that's not the intent, why there is such resistance from the government to wanting to include them, which is the attempt of this motion.

Secondly, with respect to Mr Malkowski's argument previously and yours, Mr Wessinger, about people's problem with the language, that they don't want to be treated as cases or managed as cases or whatever the argument was, I think in section 20 there are safeguards allowing and ensuring that a person has the absolute right to participate in their plan of service and the revision of the plan of service.

That's why that's all there, so that they can't be treated as cases by any of the professionals who are dealing with them and trying to provide services to them. In your own bill you've kind of inadvertently or purposely ensured those rights are in there, and we're supportive of those rights. Also in the bill of rights, if we ever get to it, there are provisions to ensure that people aren't treated as cases and as inanimate objects.

With that, I don't understand the government's resistance here. We are supportive of Ms Sullivan's motion, and I call the question, if I can do that after debating—

**The Acting Chair:** Before calling the question, Ms Carter hasn't spoken.

**Mr Jim Wilson:** Oh, then let her speak. Sorry.

**Ms Carter:** This is almost funny, it seems to me, because what you're doing on the other side of this debate is bringing forward the complaints that some presenters gave us, whether these complaints add up to a consistent picture or not. This morning we were hearing that the Red Cross either can't be integrated or doesn't want to be, and now we're being told that we're having insufficient integration.

Maybe I should point out that a large reason why we're doing this in the first place, why we're setting up multiservice agencies, is to achieve integration so that case managers can work more effectively in an integrated system. Whether you have case managers or not, if you've got different little things all over the place—

**Mrs Sullivan:** They don't have to have them. They left them out.

**Ms Carter:** But in effect they're not left out; they are certainly subsumed in section 20, because the description there of what is to be done, "the agency shall...assess the person's requirements...determine the person's eligibility...for each person who is determined to be eligible, develop a plan of service that sets out the amount of each service to be provided to the person," all this is obviously what a case manager does. So I can't quite see why we need to specify that a case manager does what is in fact case management.

Case managers, as has been said, exist now. They will continue to exist, only they will exist in a much more congenial situation for them, where they have much more ability to put together a unique plan for an individual with that individual's participation and consent. How can you at once argue that we should keep the divisions, the hard walls between the different agencies with their very clearly defined functions, and at the same time we should be getting those walls down and integrating? You can't have it both ways, and what we are doing here is integrating.

Finally, you can't spell everything out in the legislation because the more you try to do that, the more you list things and define things, the more you're going to leave something out. I don't think there is any doubt whatsoever that the case management function is very clearly part of what we're doing in this act.

1500

**Mrs O'Neill:** I have to respond, if I may, to the parliamentary assistant's response to me and I have to ask him the question again, because he said "if," and I've read section 20 now. I see the words "assess," "determine eligibility," "review," "revise." There is nothing either in that or in the list of services that talks anything about coordination.

We were told yesterday and we've been told from the beginning that the purpose of the act is holistic; it's to treat the person with respect and dignity. How can you do that when we know that no matter what this government says about funding for multiservice agencies, there's not going to be unlimited funding?

These particular professions that are named in the act will no doubt be fulfilled because they will have to be; they're mandated. Any intent to integrate the services of the various professions is not in this act; it is only in words of the act. There is no directive here that will give an MSA any motivation to do what we're saying.

I'd like Mr Wessinger to tell us what he means by, "It's guaranteed in the act" or "Things won't change," because this morning I listened to lecture after lecture about how difficult the change is going to be but it's going to happen and people are going to have to get used to it. We don't see integration or those who do the integration now as part of this act, nor do they see themselves. The word "if" certainly scares me. Maybe again I will give Mr Wessinger the opportunity to tell me how they are going to fit into this system.

**The Acting Chair:** Mr Wessinger, do you have some comforting words for Mrs O'Neill?

**Mr Wessinger:** Certainly I understand the whole

intention is to incorporate the existing case managers in the system, and they will continue to play the same role they're doing now, with the exception that I think there probably will be some other functions they'll be performing in addition. I would suggest probably that will evolve—

*Interjections.*

**Mrs O'Neill:** I would really like to hear this answer.

**The Acting Chair:** Order.

**Mr Wessenger:** That will probably evolve because of the fact that if you have an MSA, you have the case managers working for the same agency as your nursing services and your homemakers etc, there are obviously going to be some management functions and supervisory functions that will probably be, and this is just a—

**Mrs O'Neill:** This is Paul's opinion.

**Mr Wessenger:** This is looking at it as how things are likely to evolve, I would say. It will also be the individual agency that's going to determine what functions—

**Mrs O'Neill:** I'm sure that will be of interest to the case managers.

**Mr Wessenger:** If there are additional functions that case managers play, it will be certainly determined by that agency and by the board of that agency as to how it functions.

**Mrs O'Neill:** I hope the boards—

**Mr Wessenger:** I'm just saying that if I was sitting on a board of an MSA, I would certainly look at some restructured roles with respect to some of the people who are moving into that board. If I was in that position, I would be looking at this.

**Mrs O'Neill:** I just hope the DHCs and the MSAs will include case managers in their plans.

**Mr Jim Wilson:** Point of order here.

**The Acting Chair:** You had a point of order?

**Mr Jim Wilson:** The point of order is pertinent to the order. We're only on section 2 of the bill and we don't have a heck of a lot of time left. It's clear the government isn't going to vote in favour of this amendment, so let's get on with it.

**The Acting Chair:** That's not a point of order.

**Mrs Sullivan:** Just in conclusion before we vote, I want to say that, first of all, one of the key elements of long-term care reform is that it's multidisciplinary and that it integrates and brings together social services and health care services. The fact that there is inconsistency now across the province in the existence of case managers is a signal that there will continue to be inconsistency in the availability of case management when new MSAs are put together.

If there is no mandatory provision, I will guarantee you that in some parts of the province people will be better served because they will have a case management system than they will be in other parts of the province, and you can bet it'll be people in the north and the east and in rural areas who get the short end of the stick once again.

I suggest that we vote on this section.

**Mr Wessenger:** I'd just like to make a comment that we do listen occasionally to good suggestions, and certainly we're going to look at the suggestion about section 20, about seeing if we can do something about adding the word "coordination" into that section. I thought I would acknowledge that.

**The Acting Chair:** It seems to me there is no further discussion on this motion. Maybe I'll just call the vote now.

All in favour of the Liberal motion on subsection 2(1)?

**Mr Jim Wilson:** Recorded vote.

**The Acting Chair:** I hear they're asking for a recorded vote.

**Ayes**

Eddy, Jackson, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Acting Chair:** All against?

**Nays**

Carter, Malkowski, Martin, O'Connor, Rizzo, Wessenger.

**The Acting Chair:** It's been lost.

We move to the next motion. I presume this one is the PC motion now.

**Mr Jim Wilson:** Which one would you like this time, Mr Chairman? Because I don't have any particular order of all my 2(1) motions.

**The Acting Chair:** Well, I hope that all the amendments coming in will be in sequence now anyhow. I'm at subsection 2(1) again, a PC motion.

**Mr Jim Wilson:** Okay, the one I have deals with federated—

**The Acting Chair:** Oh, I'm sorry, this is the government motion.

**Mr Jim Wilson:** This is our second false start, Mr Chairman.

**Mr Wessenger:** I move that the definition of "director" in subsection 2(1) of the bill be struck out.

The reason this is being done is that there was a lot of confusion created in presenters who thought we were going to be appointing directors of multiservice agencies. Of course that wasn't the way the bill read, but we're going to get rid of it just to avoid any of that confusion.

**Mrs Sullivan:** How is the minister going to appoint directors?

**Mr Wessenger:** I think they're going to be program—no. I don't know. I may need the assistance of legal counsel to indicate how we're going to deal with that.

**Ms Czucar:** The minister has the power, of course, to appoint any of her employees as directors or program supervisors. That's an inherent power that she has. It was only with respect to the appointment of persons who are not employees of the ministry that it was needed in the bill, but there was no function assigned to directors appointed who were not employees. That was the reason we took it out.

**Mr O'Connor:** There was some confusion when we

went through the hearing process. People felt that the appointment of director actually meant the director on the MSA itself, so like a board member. That's where that confusion came from as we went through the committee hearing process. It was never that intention at all. In a matter of trying to clarify it, that's why this section is being struck out, as has been pointed out by the parliamentary assistant.

**Mr Jim Wilson:** Just let me get this straight and tell me if I'm right or wrong. You're basically ditching section 4, because there's no need for it apparently, but in 51.1—and I can't find my 51.1—what does it do? It just gives regulatory authority? No, tell me what 51.1 does, the new one.

**Ms Czukar:** Section 51.1 gives the minister the power to appoint a person as a program supervisor because specific powers of program supervisors are set out in the act with respect to inspections and so on. The power under 51.1 includes the power to appoint persons other than employees; it could include an outsider. The reason that's there is to allow the minister to appoint someone independent to do an investigation in a particular case where they would need those kinds of inspection powers or that sort of thing.

I might just clarify that the reason that "director" was taken out also is that you would need it in the act, as we do for "program supervisor," only if you were going to assign specific powers or functions that couldn't otherwise be delegated by the minister.

1510

**Mr Jim Wilson:** I was enthusiastic when I thought you were eliminating directors and program supervisors because we're always worried about the cost of administering these acts and enforcing them. Perhaps I could ask Mr Quirt: Program supervisors I assume are existing employees who will be given these new titles and powers under the act. You're not going to hire a whole army of bureaucrats.

**Mr Geoff Quirt:** That's correct. They're existing employees in our 14 area offices of the long-term care division.

**The Acting Chair:** We'll now commence the list. I presume that they have seen them in order to have a discussion. Maybe we'll just call the motion, then. All in favour of the government motion? Against? Carried.

**The Vice-Chair:** The next motion is a PC motion to subsection 2(1).

**Mr Jim Wilson:** I move that subsection 2(1) of the bill be amended by adding the following definition:

"'federated multiservice board' means a board established under section 11."

For reasons stated yesterday and earlier today, we're still pursuing our federated multiservice board, which would allow the maximum degree of flexibility at the local level and retain the current service provider agencies and allow them to get together in a cooperative partnership model to coordinate services without having to destroy those agencies, tear them down, as this bill does, and amalgamating them into a multiservice agency or monopolistic structure. We just don't agree with that

aspect of this bill and therefore are attempting to change the makeup of the MSA through this amendment and others.

**The Vice-Chair:** Speakers? All in favour of the PC motion to amend? Opposed? The motion is lost.

PC motion subsection 2(1).

**Mr Jim Wilson:** This would have been a motion subsequent to the previous motion, but since it was defeated, I won't be introducing this motion.

**Mr Wessinger:** I think we'd better clarify: Is this the multiservice one re the definition of multiservice—

**The Vice-Chair:** We did the PC 2(1) which was "federated." Is that correct?

**Mr Wessinger:** Yes. That was defeated. Which one are you withdrawing, Jim?

**Mr Jim Wilson:** I'm withdrawing the one that would have struck out the definition of "multiservice agency."

**Mr Wessinger:** Okay, good.

**Mr Jim Wilson:** Obviously, we're going to have to keep it in there now that we didn't replace it with a federated board.

**Mr Wessinger:** Right.

**Mr Jim Wilson:** Against my better judgement, I might say.

**The Vice-Chair:** The next motion is a Liberal motion regarding subsection 2(1).

**Mrs Sullivan:** I move that subsection 2(1) of the bill be amended by adding the following definition:

"'long-term care facility' means a nursing home under the Nursing Homes Act, an approved charitable home for the aged under the Charitable Institutions Act or a home under the Homes for the Aged and Rest Homes Act."

Once again, to ensure that we do have a seamless system of long-term care, a continuum, it's important that long-term care facilities be recognized in this bill, and they certainly are mentioned. This definition is identical to that which is included in Bill 101.

**The Vice-Chair:** Any speakers? Ready for the motion? Those in favour of the Liberal motion regarding subsection 2(1) of the bill? Am I too quick?

**Mr Alvin Curling (Scarborough North):** You've called the vote already?

**The Vice-Chair:** Recorded vote?

**Mr Curling:** No, did you call the vote?

**The Vice-Chair:** Yes, I'm calling it now.

**Mr Curling:** Rather speedy, Mr Chairman. Okay. Go for it.

**The Vice-Chair:** Thank you. Those in favour? Opposed? The motion is lost.

PC motion, 2(1), "multiservice agency"—

**Mr Wessinger:** That's been withdrawn.

**The Vice-Chair:** Government motion 2(1), "personal record."

**Mr Wessinger:** I move that clause (c) of the definition of "personal record" in subsection 2(1) of the bill be struck out and the following substituted:

"(c) is in the custody or under the control of the service provider."

This amendment clarifies the definition of "personal record" to include records which may be in the custody of a service provider as well as those under its control, because there may be some documents that are in the custody that would not be deemed by the holder under their control because of perhaps the nature in which the document was released to the person having custody.

**The Vice-Chair:** If no one wishes to speak to the—

**Mr Curling:** I just wanted to say to Mr Wessenger that the cooperation of the opposition to some of the government motions is just so cooperative, that other word, and I hope that on some of the motions put forward by the Liberals we get the same cooperation by the government. Those are my comments.

**Mrs Sullivan:** Not so far.

**Mr Curling:** Not so far.

**Mr Wessenger:** A few.

**Mr Curling:** Oh, we got a few, sometimes inadvertently.

**The Vice-Chair:** No further speakers? I'll put the motion. All in favour of the government—

**Mr Jim Wilson:** Just a quick question, which I thought Mr Wessenger might have included in his explanatory remarks. Just for the record, this is consistent with other legislation, and was this just an oversight first time around?

**Mr Wessenger:** Counsel has got a more legalistic aspect.

**Ms Czukar:** In fact, this amendment was requested by the people from Management Board who administer the freedom of information legislation. They suggested this in order to be consistent with the definition in other legislation. Also, in subsection 2(2) where we define "personal record," it's clear that it includes assessments and information that might come from others so that it is within the custody of the record holder, and again it's to make it clear that anything that's within the custody or under the control is included.

**The Vice-Chair:** All in favour of the government motion? Carried.

Government motion, 2(1), "program supervisor."

**Mr Wessenger:** I move that the definition of "program supervisor" in subsection 2(1) of the bill be amended by striking out "subsection 4(2)" in the second and third lines and substituting "section 51.1."

This relates to the later amendment providing for the program supervisors being appointed under section 51.1.

**The Vice-Chair:** No one wishes to speak to the motion? We'll put the motion. Those in favour of—

**Mrs Sullivan:** I have a question here. Subsection 51(1) is with respect to the Public Vehicles Act.

**Mr Wessenger:** It's 51.1. It's a new one.

**Mrs Sullivan:** Okay, I'm sorry. I apologize.

**Mr Wessenger:** It's a new provision.

**Mrs Sullivan:** But we haven't passed that one yet, so can we pass this one until the other one is passed? The

51.1 hasn't been presented as an amendment yet.

**Mr Wessenger:** I suppose, though, we have already—I shouldn't say that—probably passed some definitions that we would—

**Interjection:** No.

**Mr Wessenger:** No, we haven't. Okay, so it should be stood down, then, technically.

**Mrs Sullivan:** We can't take the vote until later.

**Mr Curling:** Is just another way of convenience, striking it out and then we'll read 51.1, and then we ask—

**Mr Wessenger:** We can do this at the same time as we—after we do 51.

**Mr Curling:** Okay.

**The Vice-Chair:** The motion is stood down.

Government motion 2(2).

1520

**Mr Wessenger:** I move that subsection 2(2) of the bill be amended by adding "in the custody or" before "under" in the sixth line.

This again relates to the "personal record" definition, and I think probably the same explanation that was given by legal counsel would apply here.

**The Vice-Chair:** Discussion? All in favour of the government motion? Opposed? Carried.

Liberal motion re paragraph 3 of subsection 2(4).

**Mrs Sullivan:** I move that paragraph 3 of subsection 2(4) of the bill be struck out and the following substituted:

"Care giver support services, including respite care."

I may withdraw this because I think that the government has fixed the respite care and we've passed that one already, haven't we? I thought we had.

**Mr Wessenger:** It's going to come up again in subsection 12(1.1). That's to add a requirement to provide services for the purposes of palliative and respite care. It was felt that was the appropriate place it should be dealt with.

**Mrs Sullivan:** All right. I will withdraw this because I believe that it's covered in government amendments.

**The Vice-Chair:** Liberal motion withdrawn.

Next is PC motion paragraph 3 of subsection 2(4).

**Mr Jim Wilson:** For the reasoning just stated by Mrs Sullivan, we'll also withdraw this amendment.

**The Vice-Chair:** Withdrawn.

PC motion regarding subsection 2(7) of the bill.

**Mr Jim Wilson:** I move that subsection 2(7) of the bill be struck out and the following substituted:

"Professional services

"(7) For the purpose of this act, the following are professional services:

"1. Case management and nursing services.

"2. Medical services.

"3. Psychological, psychiatric and counselling services.

"4. Occupational therapy services.

"5. Physiotherapy services.

"6. Social work services.

"7. Speech-language pathology services.

"8. Dietetics services.

"9. Training a person to provide any of the services referred to in paragraphs 1 to 8.

"10. Providing prescribed equipment, supplies or other goods.

"11. Services prescribed as professional services."

It's an attempt to repair, I think, the government's bill in terms of ensuring that a whole range of professional services are included.

Again, we have case management, which I think we've debated at length already this afternoon.

We felt it important to include medical services in the list of professional services because a few physicians appeared before our committee—and the Ontario Medical Association, as well as individual physicians, family physicians, those who deal with the frail elderly—indicating that they weren't sure how they fit into this act and felt that it was, in fact, sort of an anti-doctor act to leave them out of the reform of long-term care, because there's no mention of the medical profession. So, in a general term, it was suggested by our advisers that "medical services" was perhaps appropriate.

"Psychological, psychiatric and counselling services": again back to the arguments we were making yesterday about the fact that mental health seems to be left out of this stage of reform. The people who are involved in the discussions surrounding mental health reform in this province, I can tell you, ladies and gentlemen, are extremely frustrated. They feel they're spinning their wheels out there and not seeing any action, and this is an attempt to ensure that those professional services, anyway, are included in this act.

Since our previous amendments that dealt with trying to include mental health in this phase of long-term care reform and ensuring that multiservice agencies had some responsibility, and district health councils some responsibility, for planning in this stage of long-term care reform for mental health services, and also our previous amendments to deal with those discharged as a result of the closures of psychiatric beds that are currently occurring once again in this province, we tried to ensure that the MSAs would have some legal responsibility for the care and maintenance of those individuals. That failed.

Also, occupational therapy was in the bill. Social work services were in the bill originally. Just bear with me. Essentially, those are the new additions that I've highlighted, and I think some of the debate has preceded the introduction of this amendment and I need not repeat it at this time.

**Mr Wessenger:** We won't be supporting this amendment for various reasons. We've already had discussion on the case management aspect, but aside from that I think there's a problem combining case management and nursing services together. It suggests that only a nurse could provide case management services; there are many other professions that do so. It should be noted that these

are mandatory services to provide, not optional. The other thing is that I think we'd be moving a little too fast for even the opposition critics to integrate the whole medical system into the long-term care system. So that's the major one.

**Mr Jackson:** I think that's an unfair, throwaway statement rather glibly put by the parliamentary assistant. He was present when we did the health professions review act. What we're basically saying is that this legislation is far too silent on key and critical professional services which senior citizens have grown accustomed to using in this province. So for him to just glibly use an expression that we don't have time for the opposition members to integrate all these professions, if that's a valid statement, then I suspect that on behalf of all senior citizens we have every right to be fighting to make sure that you don't throw them out of the legislation. So, frankly, that's the reason for this.

This was referred to early in the process. We made indications that this section was wanting for further clarification of certain key, critical professional services, and several have been mentioned by my colleague. The one that concerns me extensively as well is the chiropractic services. The way you've written this, the minister gets to pick and choose which professions at his or her pleasure, and it does not protect certain services which are currently received by seniors in this province. So I take exception to the throwaway phrase by the parliamentary assistant.

**Mr Wessenger:** I think the point is missed that services will continue to be provided but they aren't to be required, mandated, to be provided through an MSA. It may be in some instances you'll have the development of comprehensive health organizations which will be providing more of the range of services, but to mandate that every long-term care MSA develop into a comprehensive health organization would make the goal of a long-term care delivery system impossible to effect.

If you look at what's being added here, these are mandatory services, not the question of options. There's obviously the case that an individual MSA can decide if it wishes to provide some level of, for instance, psychological services as an option. If they want to request of the minister to do that, that would certainly be optional, but what we're providing here is a mandatory basket of services to be provided.

**Mr Jim Wilson:** They're mandatory when we deal with the clause that says they're mandatory, which we haven't got to yet. I thought of that, and therefore when we get to mandatory services I agree that integrating the whole medical system—and I think you put that very well; the long-term care system is a difficult one. But given that your minister, Ruth Grier, has a real, I think, favouritism for community health centres in this province and that sort of model, where physicians are very much part of and are on the staff of and are paid for under a different model than the fee-for-service model, I wanted to make sure the physicians, if a multiservice agency in some areas of the province—I'm taking you on your word there will be some flexibility left out there for local communities—if CHCs or community health organiza-

tions are the local MSA, I just want to make sure physicians aren't thrown out of the mix. How do you provide for that?

1530

I can actually see in our part of the province there are some communities, as you know, that want CHCs. Wasaga Beach is one, for example. At some point they're going to have to be part of the mix. At some point I think the issue of physicians in the fee-for-service model in this province will be negotiated with government again, probably in the next few years. It does come up periodically. I was really concerned when physicians said: "How do we fit into this? How come we're not mentioned at all in this legislation in terms of professional services?"

**Mr Wessenger:** I think with the amendments that were made in the purpose clauses the other day, it's a clear indication of an obligation on the MSA to coordinate and to cooperate with respect to other health providers, and other health providers of course include other health professionals. So certainly the basis is there for that type of referral and cooperation and coordination.

**Mr Jim Wilson:** What about psychological, psychiatric and counselling services? We're not saying in this section that these people have to be hired on staff permanently with the MSA. This is a section listing professional services that are available as part of the basket of community services. They may be contracted by the MSA, which I assume could happen for physicians. It certainly happens for psychologists and psychiatrists and counsellors. Why can't we list them here in terms of making sure?

Again, going back to our discussion about physical and mental health, we seem to always be leaving out mental health in long-term care reform. Why aren't we listing them? For goodness' sake, we list occupational therapy and nursing and physiotherapy. They're as important as psychological and psychiatric and counselling services.

**Mr Wessenger:** With the exception of services prescribed as professional services, I think everything else that is listed will be mandated to be provided through the multiservice agency. Since that's the scheme of the act, the specific services mentioned presently in this section are those that are required to be provided through the MSA. It would change the scheme of the act to list those professions that are not mandated.

**Mr Jim Wilson:** No, that's not right. Paragraph 12(1)4 says, "The professional services referred to in paragraphs 1 to 8 of subsection 2(7)" are the mandatory services. Well, Mr Wessenger, there's no reason why we can't change those couple of little digits in section 12 to rejig, if you want to put a lower pecking order in terms of mandatory services. I don't see the harm in listing them here in 2(7) and then later in 12, saying "but they're not necessarily part of the mandatory services."

I don't think I heard physicians come forward and say, "We want to be necessarily a mandatory service." They said, "We just want mention in the bill so that we know the government's at least still thinking of us out there with respect to long-term care reform."

My preference by the way, though, would be that

psychological, psychiatric and counselling services be included in section 12 as the mandatory services. It's a two-part thing. Right now it's, "Let's list services that we want MSAs to be providing, both mandatorily and otherwise trying to provide to communities," and "Section 12 nail down exactly those that must be provided before the agency can become an MSA or that they must be ready to provide in order to be an MSA."

**Mr Wessenger:** The whole intention of specifically listing was to relate to the mandatory provision. You know, if one starts to list every health profession in the schedule, it becomes somewhat meaningless. If you're going to mention one health profession, you ought to really mention them all, every one of them, and then you'd have a list that didn't make sense, and for no particular purpose other than perhaps it would confuse, because really what we're looking at is, what is the obligation of the MSA to provide? Item 9, "services prescribed as professional services," is really to permit an MSA the flexibility of providing some optional services, or us to add a mandatory service.

**Mr Jim Wilson:** I suppose, then, if you didn't want this argument to come up, you shouldn't have section 12. You should have just listed professional services that are mandatory in this section and then after that section put "services prescribed as professional services," which is the exception you leave out of paragraph 12(1)4.

What you've done here, of course—and I understand what you've done, but what you've done with the groups, and it was clear when the witnesses were coming forward from some groups, is you've raised an expectation here, I think. When they don't see their profession listed, they feel they're left out, and I have to agree with them. You do feel left out. So I guess it's just a bit of a difference here with the way the act was done. There's probably some legal reason why it had to be done that way, but I'm not quite sure that would hold in this case, because you could have done this whole section a little differently.

But I'm still quite concerned. Could you just specifically answer my concerns about mental health services here, counselling and psychological and psychiatric services, which I think should be mandatory services. They're as important as anything you've got listed here.

**Mr Wessenger:** Well, those services can be provided under referral.

**The Vice-Chair:** Mr O'Connor?

**Mr O'Connor:** Actually, this dialogue that has just taken place covered it off fairly well. I was just going to point out that my understanding in looking at this section of the legislation was that it was left with some flexibility for the community to define some services into the future that may be needed. If those needs are recognized, then the MSA itself will come forward with that as a recommendation and the MSA would then provide those services. But I think the dialogue that Mr Wessenger and Mr Wilson have had has actually cleared that up for me quite well.

**Mr Jim Wilson:** Could I just make one comment on that? I agree with what Mr O'Connor has said, except

that communities don't have—you did use the qualifier, I think, "with approval," and you're correct. I just want to stress that, because the minister has final say on what will be delivered by the MSA in terms of new mandatory services or new mandatory professional services delivered by the MSA or provided by the MSA.

**Mr O'Connor:** That are mandatory, right.

**Mr Jim Wilson:** So let's not leave the impression out there to people that communities that really need psychiatric services as part of the basket of services, or psychological services or counselling, can just decide for themselves. They're going to have to go back to Queen's Park and ask for permission to have those as mandatory services as part of their MSA.

My preference would be that we just deal with that now and have it a goal to strive for for MSAs in their development, rather than an add-on afterwards as an afterthought that, oh, mental health services are somehow important in this province. I think you should be putting them in now and you should be encouraging MSAs to include them in the basket of services now so that it's not an add-on down the road in some disjointed way that isn't dealt with by Parliament.

**Mr Jackson:** I want to underscore my colleague's comments, because the reason we put forward this amendment is because this is the one chance we have to help define the levels of service. Let's not delude ourselves with any other understanding than the fact that we are now determining what are your baseline services and expectations for this program.

I don't know what experiences you've all had, but I've certainly had some very terrible experiences with the deficiencies of mental health support services for my frail elderly and many of the geriatric and psychogeriatric cases that are in my community. If what we're saying now by not supporting this amendment is that they're outside of the basic basket of services—don't forget, we're talking an envelope system. A certain amount of money is shipped out of Queen's Park and sent to a community and given to an MSA. The MSA looks at the legislation and says, "Here's what we are required to do and, if there's some money left over, here's what we'd like to do." The government might say, "You can provide additional service," or it could say, "If you can find the money, you can provide additional service."

1540

In the cases that are the most difficult, right now the psychogeriatric cases that are coming to my attention, it's very brutal. I mean, we chemically straitjacket these individuals. We put them in restraints. If you've ever gone into a hospital and seen what's being done to these people, they're not getting the services they require. It's frightening that as the number of psychogeriatric beds are reduced in our hospitals—I'll tell you what they're doing to them. It happened to my Scoutmaster and he died this way.

He was dumped off to a psychiatric facility and he was in with some of the most severe cases and the elderly. I couldn't go and visit him past one visit. It was so devastating to see the kinds of conditions that a senior gets put

into because there aren't the kinds of support programs and the additional counselling and psychiatric support services available to caring family members in a home setting.

I can't help but think that this is the time we have now to make sure that we do a better job in that area instead of saying, "I know we haven't been doing a great job in the past, but these are tough times and we're not going to be able to do a better job." That's exactly what we're doing here. By eliminating from the mental health perspective alone, the implications for our seniors who require these services—if you've ever experienced what they're going to end up getting in this province, you wouldn't do this to a pet, let alone to a family member.

I'm telling you that for us to fight for this amendment, we do it with some conviction based on some very terrible experiences that our caucus members have shared with us. To leave it as happenchance that the minister of the day will have sufficient sensitivity or can win enough arguments in cabinet to squeeze out enough money in my view is a huge disservice and flies in the face of every direct appeal we heard before this committee over the course of this summer's hearings.

**The Vice-Chair:** Thank you. We will now vote on the PC motion regarding subsection 2(7).

**Mr Jackson:** We'd like a recorded vote.

**The Vice-Chair:** All in favour?

**Ayes**

Jackson, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Carter, Malkowski, Martin, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sullivan, Wessinger.

**The Vice-Chair:** Motion lost. You had an alternative motion, a PC motion, alternate 2.

**Mr Jackson:** I move that subsection 2(7) of the bill be struck out and the following substituted:

"Professional services

"(7) For the purpose of this act, the following are professional services:

"1. Health care services.

"2. Social work services.

"3. Providing prescribed equipment, supplies or other goods.

"4. Services prescribed as professional services.

"Health care services

"(8) For the purposes of subsection (7), 'health care services' includes any service provided by a member of a health profession as defined in the Regulated Health Professions Act, 1991."

**Mr Jim Wilson:** Could I just comment, Mr Chair-man?

**The Vice-Chair:** Did Mr Jackson wish to comment further?

**Mr Jackson:** I'll comment in a moment. Let my colleague start.

**Mr Jim Wilson:** I'd just like to lead the comment on

this. I know Mr Jackson has a particular interest in this amendment, but it is a somewhat generally worded amendment as opposed to the previous PC amendment that was defeated for this section in terms of its trying to be all-encompassing without being exclusionary. I think it's an approach that should be welcomed by the government because, as I think Ms Carter or somebody said earlier—I'm sorry if I've got the wrong person—when you try and list everybody, you end up leaving some people out.

So this bill uses the language of the act, the government's own language, in terms of calling them health care services, social work services and then has the other language that's already in the section with respect to providing prescribed equipment and services prescribed as professional services.

It also makes sure, with the caveat on subsection 2(8), that health care services are those services that are provided by any and all of the 23, I think it is we have now, regulated health professions. That way you've included everyone, not excluded anyone and you can make an adjustment to section 12 with respect to mandatory services.

Now I know it changes the government's model a little bit, but it also, I think, prevents turf wars and fights and who can do what and it gives maximum flexibility to your MSAs to do what's right for their communities and to get the health professional, the social work professional and others, the best person to do the job, to provide the service, without tying their hands or handcuffing their hands, as I think the current wording in the legislation does.

This way they can go out and ensure that when it comes to professional services that have to be provided by that MSA, give them some time. They'll figure out those services and who's best to provide them for their area, and they can come back to government and say, "These are our mandatory services with respect to this section under 'professional services.'"

I think it's a good task that could be given to MSAs as they're developing, and of course you're not going to give them full approval to become an MSA until you're satisfied anyway as a government that they're able to provide the services they have lined up and they're the proper services for that area. If you're trying to give them flexibility and you're trying to include all of our health care professions and the hidden agenda is not to leave out the physicians or somebody else that you're maybe having a hard time with from time to time, in your own eyes, then I think you should support this legislation.

I know Mr Jackson wants to talk about chiropractic services under this act.

**Mr Jackson:** As has been noted by my colleague, we're concerned that this bill as it's currently drafted and the direction the government chooses not to expand in its definitions will restrict health professionals and their services to very specific services and it will exclude far too many groups.

I guess what we envisage for our MSA model is something for which the vision is found in the Premier's

Council on Health, Well-being and Social Justice, which talks about a wellness perspective and looking at efficiencies. When you specifically put chiropractic and other services on the outside of the circle, you deny MSAs the opportunity to examine, with their program delivery, some pretty important innovations.

The reason chiropractic comes to mind is because we've had certain reviews done in Ontario. The Manga study, which was a tripartite study on chiropractic services, showed that managing lower back pain for senior citizens in Ontario can be done more efficiently, more cost-effectively, with a greater degree of comfort and mobility for the average senior citizen than any other modality. For that reason, we would want an MSA to say, "Look, we think there's a series of our senior citizens who might need less home care if we can increase their mobility and their activation factors simply by giving them these additional and periodic chiropractic interventions."

According to the MSA model now, the MSA, with a large number of seniors trying to manage lower back pain, would have to say, "Well, you're immobilized, so now what we're going to have to do is we're going to have to bring in this support service to go help you get your groceries, we're going to have to bring in this support service to help you vacuum your home, we're going to have to get modified elevating devices and devices in your home because you can't manage lower back pain."

#### 1550

The evidence is overwhelming, yet knowing that, we're going to structure a bill which puts this option completely on the outside. Now, I can understand; it's typical of any government that wants to maintain control. For all that's being said about this sort of local autonomy—yes, we're creating a local autonomy, but, let's face it, we're controlling outcomes at Queen's Park.

In my view, if you're still going to give them a finite number of dollars at any given MSA, the trick is to let them have legislation that will allow them the flexibility to utilize the services not only of chiropractic but optometry services, chiropody and other services that are all included in the large list of services which we don't feel—we agree with the parliamentary assistant—need to be enumerated. We know who they are. We're simply saying, don't put them on the outside of the legislation, at the whim or the mood of the Minister of Health of the day, but put them inside the legislation, as we have suggested in this recommendation. This recommendation, as a motion, was crafted with considerable support from organizations that see the delivery of health services in long-term care from a team approach, and they would like these professionals involved.

Quite frankly, it simplifies the legislation. It makes it more flexible for where we believe the real power and authority should rest with the long-term care, and that's at the local level with the MSA, and not to have a highly centralized Minister of Health determining and imposing certain of these restrictions on the local MSA.

No better example can be put about why we're putting forward this amendment than the one with respect to

chiropractic services. The evidence is overwhelming that we can increase the independence of our seniors and reduce marginally the dependence on a whole range of services that come to bear on a senior citizen who has been debilitated by lower back pain and other complications which chiropractic can respond to in an effective, healing and progressive way.

I just appeal to the members not to reject this out of hand when the evidence is so clear and the nurses' professions have expressed interest in these kinds of relationships with these professions because of the results evidenced in the Manga report and others.

**Mr Jim Wilson:** Maybe members from the north haven't figured this out, but with the current model, if you have a shortage of occupational therapists or physiotherapists—I don't even need the north. Let's try Alliston, Ontario, let's try Simcoe county, where we have a shortage of those two professions. How are we supposed to start up an MSA? To get a multiservice agency going, you have to provide those services in a mandatory fashion, according to this restrictive list.

Maybe it would be appropriate to have other professionals. In the north, for example, you've always been innovative with nurses in terms of the variety of things they've been asked to do that aren't necessarily strictly what we in the south would consider a normal nursing job.

Therefore, our amendment would give you that complete range of flexibility to get your MSA up and going and tell Queen's Park, for a change, who the professionals are and what mix of professionals are best to provide the services, in this section and in other sections, that are required. We're just trying to give some flexibility to the act.

For example, leaving chiropractic services out right now is not a good idea at all; therefore you shouldn't restrict yourself. You may actually be hurting consumers, or in some areas of the province you're going to be unable to get your MSAs up and going. I don't know how you're going to solve the OT and PT problem in my county, for example.

We've got two in Orillia hospital that I know of, none available for the homes, no money available for it right now. The Ministry of Community and Social Services took all those in-home services out, with respect to PT and OT.

I don't know where you pick those out of the sky that they should be mandatory. I'm particularly thinking of children's services. Community and Social Services has gotten rid of those professionals because there just isn't any money, and they're now all driving from Cookstown and Alliston up to Orillia. They're trying to come up with different models of service delivery, but one assumes at some point that's all going to be part of the MSA's responsibility.

I think you're missing an opportunity here to expand your vision and not restrict communities and allow them to look at the whole list of health professionals and allow them to provide the services. That's my last plea on this section.

**Mr Wessenger:** It was interesting to hear this discussion, because I think it does outline a philosophical difference with respect to how we see the services being provided by MSAs, aside from their structure. That is the fact that certainly from the government perspective we feel the necessity of providing a minimum level of basket of services across the province by all MSAs.

That's the purpose of the legislation, to provide that minimum level of basket of services and to provide the flexibility in what optional services may be offered by the MSA above that. I know that what the third party is indicating is that it wants a smaller basket of mandatory services and more flexibility. We feel it's necessary to have this minimum level of basket of services in order to provide a consistent minimum level throughout the whole province.

**Mr Jim Wilson:** I agreed with everything Mr Wessenger said in the latter part of his remarks, except that we have not argued for a smaller number of mandatory services. I don't recall arguing that. In fact, we're expanding it in this section by including all health care services.

**Mr Jackson:** You were knocking us 10 minutes ago for expanding it. Don't you understand what you're doing here?

**Mr Jim Wilson:** If anything, we're giving you a brand-new horizon to pick from here.

**Mr Wessenger:** I'm sorry I misunderstood you. I was interpreting it to mean, when you suggested that some areas might not have the resources, that they might prefer to use other health professionals in providing services. I thought that was the option you were advocating, but if you're advocating more services, I think that puts any government or the taxpayer in an impossible situation. If all health services are mandatory, all social work services are mandatory for everybody in the long-term care system, this system would take up a massive amount of the health budget.

**Mr Jim Wilson:** That's a very liberal interpretation of what I'm saying. Obviously, you can't have all health services. We're trying to say to let communities—we have other amendments, which we probably won't even bother putting in now because they'll be redundant if this one gets defeated, but those would allow communities to decide what that mix can be. I don't know, in some communities where you don't have these mandatory professionals now, where are you going to pull them out of midair in order to get your MSA up and running?

**Mr Wessenger:** Mr Jackson said they should be mandatory. Are you saying all these things should be mandatory?

**Mr Jim Wilson:** He also talked about flexibility, as I did. Mandatory once the local communities tell you their mix of professionals now, what they can achieve in the next four years to get professionals they need. Rather than saying 1 to 10 are mandatory, of these services, be really daring and have a clause that says communities will determine the professional services that are mandatory. You're going to give them a certain amount of funding anyway, and there will be limitations there.

**Mr Wessenger:** Then my first interpretation was correct in the sense that—

**Mr Jim Wilson:** I agree we're dramatically changing your model.

**Mr Wessenger:** —you're advocating a funding envelope approach but allowing each MSA to determine what should be in that basket of services—

**Mr Jim Wilson:** Essentially, that's it.

**Mr Wessenger:** —which means you'd have varying services available throughout the province. Okay, I understand.

1600

**Mr Jim Wilson:** I'm trying to help you get these MSAs started, because in some areas you may not have all these mandatory services. I'm assuming you've studied the province and you feel you can get MSAs with these services in every area. But in some areas I've travelled, I can tell you, there's a shortage of some of these services now, and therefore you may actually find yourself coming back and saying, "We need more flexibility in order to even get an MSA up and running, because the professional services we're supposed to be providing under legislation aren't quite available in that area yet." It may delay you getting an MSA up and running.

**The Vice-Chair:** Thank you. The PC motion re subsection 2(7) of the bill and adding (8)—

**Mr Jim Wilson:** Can I have a recorded vote.

**The Vice-Chair:** A recorded vote. All in favour of the motion?

**Ayes**

Jackson, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Carter, Malkowski, Martin, O'Connor, O'Neill (Ottawa-Rideau), Sullivan, Wessenger.

**The Vice-Chair:** The motion is lost.

A Liberal motion, paragraph 1 of subsection 2(7).

**Mrs Sullivan:** Mr Chairman, I'm not going to put that motion forward, as it's been defeated in a previous motion.

**The Vice-Chair:** Withdrawn.

**Mrs Sullivan:** I believe the next would be a motion that reads:

I move that paragraph 7 of subsection 2(7) of the bill be amended by adding "subject to any limitation contained in the Regulated Health Professions Act, 1991" at the end.

The reason for putting this motion forward is that we know that much of home care, particularly many of the services that would otherwise, probably in an institutional or facility setting, be handled by nurses and other professionals, is now going to be in the home setting, frequently provided by informal care givers, whether they're family members, neighbours or other individuals who will be providing a large part of the direct care-giving services.

One of the things that's interesting is that in the

mandatory basket of professional services, professional services include training to any individual so they would carry out those professional services such as nursing or occupational therapy or physiotherapy or social work or speech-language pathology or dietetics. Of those, all but social work services are regulated under the RHPA, and there are rules with respect to the way delegation can be done and training can be done etc under that act.

What we're concerned about is that those rules are followed, that there is an understanding that the RHPA provisions have precedence. We have deliberately used the words "subject to any limitation contained in the RHPA" because of course social work is not included in the RHPA and therefore, because there's no limitation in the RHPA, wouldn't be subject to that.

We certainly want to be certain that if there is training being done in nursing care it is done appropriate to the professional standards and according to the act under which it can be done, or in occupational therapy or in physiotherapy or in speech-language pathology. Once again, if you look at speech-language pathology, for the frail senior much of that work isn't associated with speech training, unless there's a stroke situation, but it may well be in terms of swallowing and so on where there can be training provided, but once again it should be done by the professional and according to the law and the regulations.

We're also, I suppose, putting forward in this a concern that the generic worker, improperly trained or trained not according to the regulations, may be highly problematic in the quality of care that's delivered to an individual who is receiving home care or care in an alternative setting.

I think this is an important amendment. It's a safeguard, and we recommend it to members of the committee. If the government is not going to support this, I think the government has to come forward with some explanation of why it would not support this.

**The Vice-Chair:** Any comment from the parliamentary assistant?

**Mr Wessenger:** The comment I would make is that I must admit I don't really understand what new effectiveness it would provide. I have difficulty understanding why it would add anything to the existing law, because at present services that are required to be provided by a regulated health professional have to be provided by a regulated health professional, and there's nothing in this act that changes that.

**Mrs Sullivan:** Yes, it does: "Training a person to provide any"—

**Mr Wessenger:** Maybe the mover would like to explain how adding it to 7 is going to add anything. I don't understand why it's added to 7, to be quite frank. Maybe the mover could explain how it is going to be effective.

**Mrs Sullivan:** The person who is being trained will be providing those services which a regulated health professional otherwise would provide. The training must be provided in accordance with the regulations and with the law of the RHPA, and it should be very clear under this

act, because this act doesn't allow for that. This act says, "Train anybody to provide any of the professional services that are listed above." There's no limitation on that.

**Mr Wessenger:** If you train an unqualified person, just because they've received training wouldn't give them the right to provide the service.

**Mrs Sullivan:** You require them: "Training a person to provide" those services.

**Mr Wessenger:** But they couldn't provide the service unless they're a regulated health professional. That's why I have my difficulty.

**Mrs Sullivan:** Then why have you got 7 in in the first place?

**Mr Wessenger:** I don't know whether legal counsel could assist in that regard.

**Ms Czukur:** My understanding of why the training section is in that category is to allow assistants or others to whom those things can be delegated under the Regulated Health Professions Act, within the meaning of that statute, to be properly trained to do those delegated acts. It does allow for that to happen, and you don't need to say in this statute "subject to the Regulated Health Professions Act," because that would govern any of those acts that are going to be delegated by any health profession that's regulated under that act anyway.

**Mr Jim Wilson:** That certainly was my understanding also, that the RHPA is cast in stone and supersedes anything. This doesn't in any way take from or add to the RHPA in this regard.

I also thought it meant—I might be stretching things a bit, but we heard a lot from nurses about the different type of nursing required in the community base, and that with MSAs there may have to be some adjustment with the type of nursing or the way they deliver nursing services in the community versus those that might be coming out of the institution. I thought this allowed that flexibility, to make sure MSAs brought those people up to training rather than displace those people.

But I do understand Mrs Sullivan's literal interpretation of 7. It does sound a bit scary unless you keep in mind that—

**Mrs Sullivan:** It is scary.

**Mr Jim Wilson:** —as far as I can tell, there's nothing in here to threaten the RHPA. Therefore, I find myself in agreement with the parliamentary assistant on this amendment.

1610

**Mrs O'Neill:** It's really quite passing strange, because the people of Ontario are going to have to interpret this act in all corners of the province. We have the ability at the moment to ask legal counsel her interpretation of 7. The interpretation she gave is exactly the amendment we want to place in. I cannot understand why we don't want to be as clear as possible in this act. Let's face it, the Regulated Health Professions Act is relatively new in this province. There are still people coming and trying to understand that act, let alone taking the rider here, "Well, everybody really knows that's what we mean." I think

that's what I heard her say. So why can't we put it in, just to clarify that the training of the person, in all these acts, and there are a lot of procedures here that we're talking about, will be subject to the limitations, so that again fears will be allayed, people will know their position, know our intent?

**The Vice-Chair:** Anyone further? The mover is not present. We can't put the motion, can we?

**Interjection:** Yes, you can.

**The Vice-Chair:** Municipally you can't.

**Mrs O'Neill:** Stand this down until Mrs Sullivan comes back, if you like, for the vote.

**The Vice-Chair:** Can we do that? We can't proceed with another motion; that's the problem.

**Mrs O'Neill:** If we stand it down for the vote, can we not?

**The Vice-Chair:** Agreed that it be stood down?

**Mrs O'Neill:** For the vote until Mrs Sullivan returns.

**The Vice-Chair:** Thank you. The next motion is a PC motion re paragraphs 7.1, 7.2 and 7.3 of subsection 2(4).

**Mr Jackson:** We're here.

**Hon Mr Wilson:** I move that subsection 2(4) of the bill be amended by adding the following paragraphs:

"7.1 Services to prevent, identify and address elder abuse.

"7.2 Services for persons with dementia or with chronic psychotic illnesses, including the provision of supportive housing for such persons.

"7.3 Services for families and care givers of persons with dementia or with chronic psychotic illnesses."

By adding these services into the basket of services to be provided in this act, we are following on the recommendations of such groups as the Alzheimer society, various mental health agencies and associations that presented to this committee and spoke to us in meetings outside of this committee, particularly the mental health association, the Association of Ontario Physicians and Dentists in Public Service, the Ontario Advisory Council for Disability Issues—I can't read my own writing—which Mr Jackson may want to speak to. It's 7.1 that says, "Services to prevent, identify and address elder abuse," and I know he's had a great deal of experience with respect to elder abuse.

We think specifically that these services have to be included in the basket of services or they're going to be left out. The government's gone so far in this section as to be prescriptive with respect to other professional services that must be provided. We think they haven't gone far enough, and hence we're attempting once again here to add some more mandatory services.

I want to just quote for the committee in emphasizing the need for 7.2, which talks about services for persons with dementia. In the Alzheimer Ontario brief to this committee of August 1994, they write:

"A person with Alzheimer disease must depend on a care giver who can expect the individual to change personality, often becoming aggressive, to wander from home without warning and to lose all decision-making

ability. In later stages, care must be given on a 24-hour-a-day basis.

"Family care givers must be prepared to provide eyes, ears, hands and minds for people they love who are irrevocably and steadily deteriorating; people who may not be able to speak coherently, to think, to recognize family members, themselves, other people, places or things; who cannot make judgements or control their own bodies.

"The impact of this exhausting responsibility on family members is magnified by the daily trauma of seeing a spouse, parent or relative become a needy stranger."

They go on to suggest that because of the toll it takes not only on the individual suffering with Alzheimer's but on the family and care givers, it simply must be a mandatory service and not left, in this case, to the whims of the local MSA.

I know that the government has attempted in other amendments to ensure that support services for care givers are there in terms of respite care. In this case we're asking that services for people with dementia and people with chronic psychotic illnesses actually be included, and we also draw in supportive housing. There are enough studies around this place to indicate that you must include that as a mandatory service for these people, and 7.3 of course deals with, again, the families and care givers in a mandatory way. Your other amendments that try to deal with care givers and families and respite care aren't mandatory. They're nice and flowery and wonderful and they're sort of rights and responsibilities, but they're not mandatory.

This is the section we're dealing with now, in 2(7), that to me deals with the actual teeth and the actual services that must be provided and funded by the government, although funding's questionable and we'll have some amendments to deal with guarantees on that at some point. But Mr Jackson may want to say something about elder abuse.

**The Vice-Chair:** Mr Parliamentary Assistant wished to comment, Mr Jackson.

**Mr Wessinger:** We will not be supporting this amendment because many of the services listed are covered elsewhere. If we start with 7.1, "Services to prevent, identify and address elder abuse," that was one of the basic purposes of the Advocacy Act. So that's how we see that being delivered in that area.

With respect to 7.2, it is true that the long-term care system does deal with some persons—particularly it deals with people with Alzheimer's, but the aspect with respect to supportive housing, that's a separate program and not part of the long-term care funding. Well, it is part of long-term care funding, but it's not part of the multi-service agency funding.

With respect to 7.3, we already have under that clause care giver support services, and I would suggest that would cover the respite, with respect to care givers, of persons with dementia and chronic psychotic illnesses.

**Mr Jackson:** I'm perplexed in the extreme to hear the parliamentary assistant suggest that somehow we don't have to concern ourselves about elder abuse because there

is an Advocacy Commission and a separate piece of legislation floating around in the bowels of this building somewhere.

Whether you think the Advocacy Commission's going to work or not, it shouldn't be an opinion from us politically. I want to advise the members of this committee that while we've been cloistered in this room today, the room adjacent to us was a press conference from not only the service providers but also the clients, the vulnerable in this province, who have been roundly condemning the Advocacy Act for its structure and its content and they have resolutely suggested that this piece of legislation is not the panacea the government has suggested it is.

I remind the parliamentary assistant that his government cut \$52.5 million of front-line psychiatric services, which is why my Scoutmaster, Bill Orchard, was subjected to the dehumanizing experience that he went through until he died of Alzheimer's. Just to test this point, Parliamentary Assistant, I know you've been stonewalling the issues of psychiatric support services around chronic psychotic illnesses, dementia and so on. I'm going to ask that these three issues be separated for purposes of a vote.

I cannot in my imagination believe that your government and your Minister of Citizenship are going to sit by idly and watch you vote against the recommendation that we should even have the audacity to consider elder abuse programs and support services for seniors receiving extended care in the community.

1620

I can't believe that you've been the parliamentary assistant to the Minister of Health for so many years now—four years, is it?—and it's escaped you how the elements of abuse are occurring when people are isolated. We have limited cases of institutional abuse because you've got eight people in the room and 12 different professionals popping in on you every day.

When people are isolated in their homes, that's where the growing cohort of elder abuse is occurring in this province. It isn't occurring in a hospital bed. They put chemical straitjackets on our seniors, they put physical restraints on them, there's that form of abuse, but there's a whole broader definition of abuse going on in the privacy of people's homes—read "in their communities."

Look at what we offer in this legislation. I want to ask the parliamentary assistant to go to the next paragraph. He's suggesting that we don't need a reference to elder abuse in this bill, but if we go to the next section on homemaking services, my God, the government of Bob Rae makes sure that doing laundry and ironing is fixed in this legislation. That's how important ironing is. But elder abuse?

Your own minister has said it's a growing problem. The police have identified it as a priority in struggling with the social contract and reduced revenues to deal with this problem. Now you're going to put a whole series of additional professionals and non-professionals into people's homes, into the privacy of their homes, to provide services, and they're a government agency to boot, and you're going to say, "By the way, our govern-

ment thinks that elder abuse programs will be covered by the Advocacy Commission."

Again, Parliamentary Assistant, you're also a lawyer. You would have read the Advocacy Act. You'd realize that once a case of elder abuse is identified, then you bring in the advocate. Then the advocate says, "You have the right to say no to this program." They already have the right to say no. We're talking about working with people where we've got suspected cases of abuse and building that into the program. I can't imagine you don't understand how elder abuse programs operate in this province, that you feel that threatened by this simple part of the amendment.

It's clear for financial reasons, you're stonewalling mental health services for seniors. That's clear. You've done it four or five times today. But this is the first time elder abuse has come up and we're still waiting for something concrete out of your government. Here we get one little example of a case where we can entrench it as something that a senior citizen can expect in their basket of services and you're saying, "We don't think it's necessary because we've got an Advocacy Commission down the street that may or may not be up and running in the next two and a half years."

Mr Chairman, I want to formally request that we divide this motion, and I hope you'll support that request, that we vote on paragraph 7.1, "Services to prevent, identify and address elder abuse," as a separate vote, and separate them. We can do 7.2 and 7.3 as one vote if that's more convenient. And I'm going to request a recorded vote.

I want to remind the members of the government, a lot's being said about, "Jane Leitch doesn't agree with you and she agrees with us." Well, I'm telling you, Jane Leitch and all the thousands of senior citizens in this province agree that this clause should be included, and you are going to turn your back on it. I'd like to call the question, Mr Chairman.

**The Vice-Chair:** Mrs O'Neill.

**Mr Jackson:** I called the question, Mr Chairman.

**The Vice-Chair:** Your first request to split the motion—it's one motion, so we will deal with the motion in one vote.

**Mr Jackson:** That's your ruling?

**The Vice-Chair:** Yes. Mrs O'Neill, did you wish to speak?

**Mrs O'Neill:** We are going to be voting on the three sections together, is that what you've just ruled?

**The Vice-Chair:** Yes.

**Mrs O'Neill:** All right. I will then not need to speak at this point.

**The Vice-Chair:** Any other speakers? If not, the PC motion, paragraphs 7.1, 7.2 and 7.3 of subsection 2(4). A recorded vote you called for, I believe, is that correct? All in favour of the PC motion?

**Ayes**

Jackson, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Carter, O'Connor, O'Neill (Ottawa-Rideau), Martin, Rizzo, Sullivan, Wessinger.

**The Vice-Chair:** Motion lost.

Before proceeding with the next Liberal motion, could we return and call up for a vote Liberal motion re paragraph 2(7), which had been stood down previously. Those in favour of the Liberal motion at this time? Opposed? Motion lost.

Liberal motion, subsection 2(7) of the bill, adding 10.

**Mrs Sullivan:** I move that subsection 2(7) of the bill be amended by adding the following paragraph:

"10. Psychiatric, psychological or counselling services provided to persons with dementia or with chronic psychotic illnesses while the person is at the same time receiving community services."

This particular section is included because of the high prevalence of dual diagnoses, particularly in the elderly population although not limited to the elderly population, where one of the diagnoses may be a physical illness or impairment and another may be a mental or psychological or psychiatric impairment, where the need for services under the mandatory basket may well not be included or recognized.

We have been throughout these hearings, as you know, very concerned that mental health reform is occurring in one silo and that long-term care reform is occurring in another silo, and in a community service situation, in a scenario where an individual is outside of a facility or an institution where there are fairly routine mental health services, the assurance that those services will be available and will be provided to the individual is certainly lacking for long-term care services.

We felt, along with the extremely effective intervention from the doctors and dentists in public service and from organizations such as the Alzheimer Association, that the linkages had to be established, had to be obvious and, for those people who are receiving community services with dual diagnoses or even a single diagnosis, there had to be appropriate safeguards and assurances that these services would be in place and available through the same service centre that their other services are available from.

**1630**

As I've indicated, in our view this issue is not limited to the elderly population. It does include young people, many of whom have undergone a traumatic scenario where perhaps a car accident or a devastating or catastrophic illness will require counselling and other mental health care to assist them. The middle-aged who are in a longer-term impairment situation may also need services such as this. What we're saying is that there should be an opportunity for a multidisciplinary, coordinated approach to that provision of services, that the MSA should be able to link the need or the identification of the need and ensure the availability of those services in an integrated, comprehensive way. We believe that this should be included in the mandatory basket.

The limiting factor in this amendment, as you know, is that the MSA would be responsible for the provision of those services to individuals who are at the same time

receiving other community services which have been identified. In other words, this is not a total population situation. The MSA will not become responsible for the needs of the entire population but only for those who are receiving services through the long-term care service system.

Once again, I think that the information and the concern that was placed before the committee during the hearing process and throughout the process of mental health reform is compelling, and I urge you to accept this amendment.

**Mr Jim Wilson:** I just wonder what's going on here in terms of the commitment of the Liberal caucus to this amendment, because they've just voted against three different PC amendments that dealt with the whole continuum of health care services. I didn't hear any comments supporting even parts of our motions. They voted against the elder abuse provisions, the services for persons with dementia or chronic psychotic illnesses, services for families and care givers of persons with dementia and chronic psychotic illnesses and they voted against psychological, psychiatric and counselling services in our other amendment without even any verbal support.

**Mrs Sullivan:** On a point of order, Mr Chair: The member distorts the position that we have been taking throughout the entire public hearings—

**Mr Jim Wilson:** You can't have it both ways, Mrs Sullivan.

**Mrs Sullivan:** —and indeed selectively picks from some badly crafted motions that he's put before the committee to disparage our legitimate and very deep concern in this area.

**The Vice-Chair:** That's not a point of order. Proceed, please, Mr Wilson.

**Mr Jim Wilson:** It was an interesting point, though. I enjoyed it. The record will clearly show that you voted against these.

**Mrs Sullivan:** You're darned right. They were bad ones.

**Mr Jim Wilson:** Oh, they were bad ones.

**The Vice-Chair:** Please proceed, Mr Wilson.

**Mr Jim Wilson:** Let's elevate the debate here. I will support your wonderfully worded motion here, even though it is not wonderfully worded. But the problem is, if you don't support us on these things because you find a problem with a word or two, how in the world are we ever going to get the government to come around? The track record in the last couple of days has been pretty bad in having the government come around to any of this.

I do want to point out that the Canadian Mental Health Association in its presentation to this committee mentioned specifically that the Ontario division of the CMHA said it was particularly concerned that those with a psychiatric disability are not specifically mentioned in the description of those who will be served by long-term care facilities. They went on to talk about the tremendous need to consider elderly persons, in their case, with a mental illness who require psychogeriatric and other long-term care support services. They presented us with staggering figures.

This particular figure is from a 1993 Ministry of Health study that said approximately 27% of those in provincial psychiatric hospitals are individuals over 65 who have a psychiatric problem. From the Mental Health/Long-Term Care Interface Working Group in 1994 a statistic was thrown at us that said that an analysis of the prevalence of mental health problems among the elderly in all hospitals and long-term care facilities has shown that up to 50% have at least one psychiatric problem. That's the facilities side.

The next deals with similar problems on the community side. As they age, individuals develop cognitive disorders which are more common in the elderly. For example, the incidence of dementia in Canadians over the age of 65 is estimated to be 8%, while the estimate increases to 34.5% of those over 85 years of age. Approximately—and here's the important part—30% to 40% of Canadian seniors in long-term care facilities have a moderately severe dementing illness and up to twice as many people with dementia live in the community, so a staggering number of people require this protection, this inclusion of mandatory services in the act. We are supportive of it and we are consistent in our support of these services.

**Mr Wessinger:** We will not be supporting this motion, because the effect of it would be additional funding would have to be provided because it's additional cost to the MSA. There's additional service being added. That's the first aspect.

I wouldn't disagree that services should be available, but there's the question of who provides those services and which system provides it. It is our position that the community mental health should provide these services and it should be funded and delivered through that process.

**Mrs O'Neill:** As most of the providers, and certainly now some of the recipients who have gone through care know, this bill is really all about bucks. It's really all about limiting services and, if necessary, being put on a waiting list.

I'm having a lot of trouble with this, and I hope the parliamentary assistant will respond further, because we had a very extended discussion on case management. We were told that services weren't really going to change and that somebody would be doing it—we're not really sure who—and then we will refer to section 20 of the act. We were told the whole person would be treated through section 20.

Yet when we present this amendment, which again treats the person as a whole person, even to the case of records, which definitely are referred to in this act, we're told: "No, the person's going to have all these needs that have been outlined in the section of the act, whether it be ironing or whether it be personal hygiene, but if there's anything wrong with their mental abilities, folks, they've got to go somewhere else. They just have to go somewhere else, and we may or may not talk to the other people. We may refer them." I think that's the most I've been able to get out of this government about this matter.

This is very disconcerting: psychiatric, psychological or counselling services, while the person is in and at the same time receiving community services, no doubt

through the MSA. How can we have any confidence that mental health will ever be attended to by an MSA board or through an MSA agency? I really have not got any guarantees, the people of Ontario don't, and what we're hearing is, "There isn't much money for mental health, folks." Maybe that's why we're dragging our feet on the reform.

**Mr Jim Wilson:** At least, in a sort of ironic way, I'm pleased to hear the parliamentary assistant admit the truth on this, because it seemed to me the last couple of days we dodged everything but the funding question, and to at least come forward and admit there isn't money is something we can understand. But I still don't think that should preclude you, because there is money in the mental health sector. It should be given a higher priority in your ministry. I could name a few programs you could drop.

The fact of the matter is there isn't money right now, but you do have mental health reform going on. Your own discussion papers talk about MSAs. I think it would be very wrong, as Ms O'Neill has said, to leave it out right now. I don't know whether you realize it or not, because maybe you don't get to talk to all the groups we get to talk to, but there's mass confusion going on in mental health reform right now. They don't know where they fit into this picture. They feel like, as I said before, they're spinning their wheels, and your MSAs aren't going to be popping up overnight anyway. There's a time frame in here that allows them time to get up and running and to have these services ready.

I think you should be proactive. You should be trying to advance that mental health agenda and programs and including them in some way in this legislation so that you partly fill that big need out there with respect to health care reform when people say to us constantly, "Well, we have no idea what the overall picture is in health care in this province." At least here you could help solve part of that puzzle by making sure mental health is part of the MSA structure.

**1640**

Surely over the next four years your government or the next government is going to come to some conclusions with respect to mental health reform. You have to, because you can't keep having these people going to meetings every night and spinning their wheels. I would put them in now and start to redirect the funding that's going to be absolutely critical, because right now is when you're closing the psychiatric beds. Right now. You've got to get this legislation, because Parliament's a little jammed up, if you haven't noticed, and it's going to be hard for the next government, which will want to, I think, undo some of the things of the current government, to find the time to go back to Parliament and do these things.

I know you have regulatory authority in this bill, or will have, to add services, but I think as part of the planning puzzle right now you should be putting these services in, you should be talking about mental health services, and then that would send a signal to your own 12,000 bureaucrats that this is a priority in your ministry: Funding's got to be found, other programs have to be

dropped, and money has to go to mental health services in the community. You box yourself nicely and purposely or else you can't get your MSAs going up.

I think that would be a way to advance this agenda and you should be supporting that and championing mental health, because communities need these services now and there may not be time, or parliamentary time, next year to be revisiting these acts.

**Mr Wessinger:** I'd just like to respond. I think certainly the member raises the whole question of mental health reform, and if we look back on closing institutions and the psychiatric hospitals, that started way back in 1970. One of the problems back then, everybody admits, was the fact that there was not the investment in community mental health.

I think definitely our government recognizes the fact we have to make an investment in community mental health, and I can assure the member it is the intention of the government to make that investment in community mental health and to not leave people in the lurch as psychiatric beds close. It will not require legislation in order to do that; it will merely require policy directions with respect to funding decisions.

I'm optimistic that we're going to have the mental health services in the community more than provided so that we will be able to provide some of these services through the referral system to community mental health in order that people can receive the services they need. It's not a question of whether they get the service or not; it's a question really of how the two systems mesh together. There certainly is a need to mesh the two of them, to coordinate the two of them together, and there certainly is a need for investment in community mental health. I recognize that.

**Mr O'Connor:** I appreciate this opportunity to speak on the importance of mental health reform. As I said yesterday in this very committee room, I know how strong my fellow colleagues are in advocating for mental health reform to continue. We will, as a government, address mental health reform in an appropriate fashion. It will be dealt with.

We recognize the need for programs to take place at a community level in mental health reform. It's not something that is included in detail in this bill because this bill is to deal with long-term care reform. I recognize that there are some areas where the two will cover off from each other, but we don't want to have the MSA out there providing all the mental health services that need to, in some cases, be created in communities, because there are a lot of communities where there certainly are some deficiencies.

This government is, I know, very committed to mental health reform. The document that was put out by the Ministry of Health isn't merely a document that says, "We're going to do it some day, whenever we get around to it." There's actually a lot of work continuing to take place on that very important issue, and I find it rather passing strange that we end up getting sidelined by the discussion about who's going to move forward on what reform and when. The reality is that the long-term care reform is something that is before us right now and it's

something that we are dealing with, and hopefully we can try to zero in on exactly the legislation that's before us and through the clauses as we go through this clause-by-clause process.

#### *Interjections.*

**The Vice-Chair:** Order, please.

**Mr O'Connor:** Thank you for this opportunity to speak over the heckling of my colleagues opposite.

**Mr Jim Wilson:** One final point is that you've already dismissed three PC motions trying to deal with these things, two specifically. Don't let this one slip by you. If you're not happy as parliamentarians over there, and there are enough of you right now with some freedom, if you exercise it, to tell your own government that you want mental health in here, pass this amendment and over the next four years MSAs will have to integrate and mental health reform will have to advance to the point where something actually gets done.

If you're not happy as parliamentarians right now, this is your opportunity. Put your hands up, vote along with this amendment, get it into the legislation, send a very powerful message to your own government, to the Ministry of Health and to the other ministries involved that you want action on this. That would be a very positive thing to do. You could do it on behalf of your constituents.

I'm tired of NDPers—and you've been doing it for 20 years—telling me how important this stuff is. You've been in government four years and nothing has happened. You've set up more feel-good committees about empowering consumers and all this sort of nonsense, hiring an army of advocates. The bottom line is the services and you've got an opportunity right now to show some backbone, some leadership and actually lead your government in a policy direction that needs more attention and action.

**Mr Martin:** Are you suggesting we raise the deficit?

**Mr Jim Wilson:** I'm suggesting—

**The Vice-Chair:** Thank you for your comments. Any other speaker? If not, the Liberal motion amending subsection 2(7).

**Mrs Sullivan:** Recorded vote.

**The Vice-Chair:** All in favour?

**Ayes**

O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Carter, Martin, O'Connor, Rizzo, Wessinger.

**The Vice-Chair:** Motion lost.

A Liberal motion amending section 2 of the bill by adding (8) and (9).

**Mrs Sullivan:** I move that section 2 of the bill be amended by adding the following subsection:

"Performance of professional services

"(8) A professional service mentioned in subsection (7) that involves the performance of a controlled act described in subsection 27(2) of the Regulated Health

Professions Act, 1991, shall only be performed by a member of a health profession in accordance with that act and the applicable health profession act.

"Same

"(9) For the purposes of subsection (8), 'health profession act' means a health profession act as defined in section 1 of the Regulated Health Professions Act, 1991."

We've had comparable debate on another section. It's clear that we feel strongly that the professional services must be provided only by professionals.

**Mr O'Connor:** I agree with the intent behind this motion but don't want to undermine all the hard work that went into the Regulated Health Professions Act. That's a standalone piece that was very important. It went through a long consultative process and I don't believe that it's necessary to add this at this point. The Regulated Health Professions Act went through extensive consultation and defined exactly what were the regulated health professions. I don't think we need to add this all to this legislation.

**Mr Jim Wilson:** Unless I'm reading this wrong, it doesn't make any sense to me. What the Liberal motion says is, "A professional service mentioned in subsection 6(1)—6(1) is personal hygiene—

**The Vice-Chair:** It was changed to 7 and corrected, apparently.

**Mr Jim Wilson:** Oh, I'm sorry. It makes perfect sense and I won't be supporting it because I think it's redundant.

**1650**

**The Vice-Chair:** Any other speaker on the motion? If not, those in favour of the Liberal motion regarding section 2 of the bill by adding subsection 2(8) and subsection 2(9)? All in favour? Opposed? The motion is lost.

There were several motions, I understand, regarding section 2 that were stood down. We'll continue with section 3, then. The first is a government motion regarding paragraph 1 of subsection 3(1).

**Mr Wessinger:** I move that paragraph 1 of subsection 3(1) of the bill be struck out and the following substituted:

"1. A person receiving a community service has the right to be dealt with by the service provider in a courteous and respectful manner and to be free from mental, physical and financial abuse by the service provider."

This basically adds financial abuse, and I believe there are other motions by the opposition in the same manner, so we should be fairly unanimous on this one.

**Mr Jim Wilson:** Yes, I think that the parliamentary assistant is somewhat correct. I'll certainly be supporting this motion. I wouldn't give blanket approval, though. A couple of the financial mentionings coming up deal with not just financial abuse. So I'm certainly supportive of this, although I don't rule out that some of the other amendments might help to clarify this one. But given that we're at this one right now, I think we'll have to support it.

**Mrs O'Neill:** The parliamentary assistant just said

that this is going to attend to financial abuse. We talked earlier today, and I feel very strongly, about people being treated in a condescending manner. I wonder why the words "has the right to be treated" have been changed to "has the right to be dealt with." There is a difference. "Dealt with" is, again, you're making the decisions about the person's competence or whatever; "treated" requires much more equality in the relationship.

**Mr Wessenger:** I'll ask legal counsel to explain that.

**Ms Czukar:** We changed the word "treated" to "dealt with" in I believe it's three of these sections in order to deal with some concerns expressed by some groups that the word "treated" might be interpreted in a narrow medical treatment sense, and we wanted to make it clear that we were including social services as well and to be less restrictive in that way.

**Mrs O'Neill:** I thought that would be the answer, but I don't like it.

**Mrs Sullivan:** We'll be supporting this amendment, and we believe that it covers some of the issues not only of elder abuse but abuse of people of all ages who are accessing the long-term care system, including financial abuse. You will recall that during the public hearings it was one of my concerns and the concern of some agencies that the bill-paying provisions that are included in the community service basket could open themselves to abuse. We like this addition.

**The Vice-Chair:** Any other speakers? If not, government motion, paragraph 1, subsection 3(1), all in favour? Carried unanimously.

The next is a PC motion, paragraph 1 of subsection 3(1). As was mentioned, this is similar.

**Mr Jim Wilson:** Yes. Since it is very similar, it's redundant and will be withdrawn.

**The Vice-Chair:** Thank you. Government motion, paragraph 2 of subsection 3(1).

**Mr Wessenger:** I move that paragraph 2 of subsection 3(1) of the bill be struck out and the following substituted:

"2. A person receiving a community service has the right to be dealt with by the service provider in a manner that respects the person's dignity and privacy and that promotes the person's autonomy."

This just changes the word "treated" to "dealt with." As well, "community service" is changed to "a community service." It's again very technical legal language.

**The Vice-Chair:** Any speakers? If not, all in favour of the government motion? Opposed? Carried.

Government motion regarding paragraph 3 of subsection 3(1), and there's a replacement. Is that correct?

**Mr Wessenger:** I move that paragraph 3 of subsection 3(1) of the bill be struck out and the following substituted:

"3. A person receiving a community service has the right to be dealt with by the service provider in a manner that recognizes the person's individuality and that takes into account the person's needs and preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors."

This amendment has minor changes. The word "treated" is changed to "dealt with" and "community service" is changed to "a community service." It's again very technical.

**Mrs Sullivan:** I'm not certain that these are all technical. I think there is a substantial change here in that what the government has done is to add the words that the individual "has the right to be dealt with by the service provider in a manner that recognizes the person's individuality" and so on.

There must be some reason that "service provider" has been included. You have to go back, of course, and look at the definition of "service provider," which may or may not include an MSA. I don't understand why the limitation has been put to "service provider" rather than, for instance, the person who answers the phone at the MSA or the person to whom the individual is referred. I don't get it. I don't understand why there's only one class of individuals who have to treat a person "in a manner that recognizes the person's individuality."

**Mr Wessenger:** I'm going to ask legal counsel to explain, but it should be noted that an MSA would be under the category of a service provider.

**Mrs Sullivan:** Well, is it?

**Ms Czukar:** Yes. "Service provider" is the most all-encompassing definition under the bill. It includes approved agencies and multiservice agencies as well as all other service providers. The reason for inserting the words "by the service provider" in these sections is because 3(1) opens with saying, "A service provider shall ensure that," so the obligation in the bill of rights is on the service provider.

The way that it was written previously we were concerned on closer reading after the hearings might be too broad, that the service provider would be put in the position of being required to ensure certain rights being respected when they would have no control over the situation. So, in these cases, we've said that it's the ways in which the service provider is dealing with the person that we believe the service provider can be obligated to behave with respect to.

1700

**Mr Jim Wilson:** Since I have a very similar amendment to put forward next, I was wondering if the government would be friendly to amending its amendment as follows. That would be that after "recognizes the person's individuality and" we delete "that takes into account" and instead use the language of my amendment that says "that is sensitive to and responds to" the person's needs and preferences, including preferences based on ethnic, spiritual—I think it's better than simply leaving it that the requirement under the bill of rights is to take "into account."

I'm far more comfortable with the language "that is sensitive to and responds to," particularly the word "responds," which to me connotes more action than simply taking into account, because the government's been taking into account a number of our amendments over the last two days and we've had very little action with respect to support.

**Mr Wessenger:** I think we have some concern with the language in your proposed amendment. I think we have difficulties with the aspect of "responds to" and also had some difficulties with respect to—

**Mr Jim Wilson:** "That is sensitive to and responds to," and in your language, "the person's needs and preferences, including preferences based on ethnic" etc.

**Mr Wessenger:** Just say "is sensitive to and responds to."

**Mr Jim Wilson:** Rather than "that takes into account."

**Mr Wessenger:** Right. That's what you're suggesting. If legal counsel says it's all right, then that's fine with me.

**Mr Jim Wilson:** Okay. Well, let's do that. Do I need to move a motion in that regard or can the parliamentary assistant amend his?

*Interjection.*

**Mr Jim Wilson:** Mr Chairman, I move an amendment.

**Mr Wessenger:** I'll get legal counsel's—

**The Vice-Chair:** We'll replace the motion by changing, in the second—

**Mr Jim Wilson:** No, I'd like to move an amendment. I move that the government's amendment amending paragraph 3(1)3 of the bill be amended by striking out "that takes into account" after "and" in the third line and substituting "that is sensitive to and responds to."

**The Vice-Chair:** Discussion on the amendment? No discussion.

All in favour of the amendment to this motion presented by Mr Wilson? Thank you. Carried.

Now the government motion, as amended. Discussion? Ms O'Neill, you had your name down.

**Mrs O'Neill:** I think I'll pass.

**The Vice-Chair:** Thank you. Anyone else?

The government motion to paragraph—yes, Ms Sullivan?

**Mrs Sullivan:** I have one other question of the parliamentary assistant. I would like an explanation of why regional differences were taken out of the original drafting.

**Mr Wessenger:** I'll ask legal counsel to explain that one.

**Ms Czukar:** The wording here was changed to "needs and preferences," the person's needs and preferences. The former wording was more general with respect to differences. Now that we've related it specifically to personal

needs and preferences, it seemed that regional differences weren't really relevant in the same way, and so we've used the same language that we've used in Bill 101 and other places where we've been talking about personal needs and preferences. Actually, those factors relate only to preferences.

**Mrs Sullivan:** Are preferences with respect to regional issues or geography included elsewhere? Have you added them back? It's a singularly important issue with respect to people who will be of course seeking care in their community and who want an interlinking service within their community.

**Ms Czukar:** I guess the issues of where people will receive services from within the MSA areas are dealt with further on in the bill in sections 11 and following with respect to MSA. I think the term "regional differences" in paragraph 3 of the bill of rights, as it was written before, was probably referring more to the issue of where people came from when it said "respects regional differences," rather than personal preference kinds of issues. So I think it was also vague there.

**The Vice-Chair:** Anything further? If not, government motion re paragraph 3(1)3, as amended. All in favour? Opposed? Carried.

It's now after 5 o'clock. Is there any other business that needs to be mentioned before we adjourn the meeting?

**Mrs Sullivan:** I'd like a clarification from the clerk. Since we have one more day of hearings on this bill and several dozen amendments to proceed with. I'd like a clarification on the process if we do not complete the entire clause-by-clause and if there would be consideration of seeking additional time from the House leaders to complete the entire clause-by-clause when the House resumes early next week.

**Clerk of the Committee (Mr Doug Arnott):** The bill remains referred to the committee when the House resumes. The committee normally meets Monday and Tuesday afternoons and the committee could decide at the conclusion of tomorrow or through its subcommittee, if it was preferred, how the committee would be proceeding with clause-by-clause consideration. The Chair of the committee had previously asked for a subcommittee meeting on Tuesday afternoon to consider the committee's future business.

**Mrs Sullivan:** Thank you very much. I appreciate that.

**The Vice-Chair:** Anything else? If not, the meeting is adjourned to 10 am tomorrow morning, same location.

*The committee adjourned at 1707.*





## CONTENTS

Wednesday 26 October 1994

<b>Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,</b> projet de loi 173, M <sup>me</sup> Grier .....	S-2409
---	--------

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair /Vice-Président:** Eddy, Ron (Brant-Haldimand L)

**\*Acting Chair / Président suppléant:** Curling, Alvin (Scarborough North/-Nord L)

**\*Carter, Jenny** (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

**\*Martin, Tony** (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Curling, Alvin (Scarborough North/-Nord L) for Mr McGuinty

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

Malkowski, Gary (York East/-Est ND) for Mr Hope

Sullivan, Barbara (Halton Centre L) for Mr Beer

Wessenger, Paul (Simcoe Centre ND) for Mr Owens

#### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Wessenger, Paul, parliamentary assistant to the minister

Quirt, Geoff, acting executive director, long-term care division

Czucar, Gail, counsel, legal services branch

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Filion, Sibylle, legislative counsel

C4201  
X612  
-577

Publications



S-74

S-74

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Thursday 27 October 1994

# Journal des débats (Hansard)

Jeudi 27 octobre 1994

Standing committee on  
social development

Comité permanent des  
affaires sociales

Long-Term Care Act, 1994

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



*50th anniversary*

*1944 – 1994*

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Thursday 27 October 1994

Jeudi 27 octobre 1994

*The committee met at 1014 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Vice-Chair (Mr Ron Eddy):** Good morning, ladies and gentlemen. Welcome to the social development committee, which is considering Bill 173, clause by clause.

The next amendment to be considered is a PC amendment to paragraph 3(1)3. Mr Wilson, did you wish to speak to this? I believe this first one of yours is similar to a previous one passed.

**Mrs Barbara Sullivan (Halton Centre):** It's infuriating.

**Mr Jim Wilson (Simcoe West):** It's infuriating? That means I might have to say something about it. Which one are you on, Mr Chairman?

**The Vice-Chair:** It's PC motion paragraph 3(1)3.

**Mr Jim Wilson:** I move that paragraph 1 of subsection 3(1) of the bill be amended by striking out "mental and physical" in the last line and substituting "mental, physical and financial."

It may be somewhat redundant, if I can remember what the previous government bill was—and perhaps the parliamentary assistant would help me—that included "financial."

**Mr Paul Wessinger (Simcoe Centre):** Yes, I believe that's already been dealt with. I think you're on the wrong clause. What the Chair is referring to is "move that paragraph 3 of subsection 3(1)...." I believe you had asked that ours be amended by incorporating the words "sensitive to and responds to" in our motion. I don't know whether that means you wish to withdraw this one or whether you still wish to proceed with it.

**Mr Jim Wilson:** Oh, yes. I will withdraw. Thank you.

**The Vice-Chair:** That is withdrawn.

The next is a government motion regarding paragraph 3(1)4.

**Mr Wessinger:** I move that paragraph 4 of subsection 3(1) of the bill be amended by striking out "community services" in the first line and substituting "a community service."

This is just in line with all the others where we've been changing "community services" to "a community service."

**The Vice-Chair:** Any comments?

**Mr Jim Wilson:** Agreed.

**The Vice-Chair:** All in favour? Opposed? Carried.  
A Liberal motion regarding subsection 3(1) of the bill.

**Mrs Sullivan:** I move that subsection 3(1) of the bill be amended by adding the following paragraph:

"4.1. A person receiving community services has the right to participate in the development of the person's plan of service, in any revision of the plan and in an assessment of the person's requirements or requirement changes under section 20."

This amendment is put forward because, despite all the rights which are included in the bill of rights, there is no right provided for individual participation in the plan. We've heard a lot of rhetoric about how concerned the government is about individuals being able to be a part of and participate in the decision-making with respect to their own plan. If you look at subsection 3(6), the issues I'm concerned about are not included. That section says the person can "raise concerns or recommend changes in connection with the community services." It doesn't say the individual has the right to participate in the development of his or her own plan and in changes which might be made to that plan over a period of time.

We are concerned about that. We feel that the information, the right to raise concerns, isn't enough, that the right to participate has to be spelled out and ought to be included in the rights section of the bill.

**Mr Wessinger:** Ms Sullivan, there are some difficulties with respect to the language in your motion. We agree in principle with what you're trying to achieve, but I wonder if you might be prepared to take a look at a motion that legislative counsel has drafted, and perhaps if they could give some explanation to you of the reason for the changes, you might consider substituting it for your motion.

**Mrs Sullivan:** Do we have that motion? Does everybody have that motion?

**Mr Wessinger:** No, we don't.

**Mrs Sullivan:** Well, perhaps everybody should have it so that we can all participate in the discussion.

**Ms Gail Czukar:** That's the only copy.

**Mrs Sullivan:** Then could we stand this down so that everybody on the committee—

**Mr Wessinger:** Yes, we could stand it down.

**The Vice-Chair:** It's agreed, then, to stand down the Liberal motion at this time until the copies are circulated.

The next is a government motion to amend paragraph 5 of subsection 3(1).

1020

**Mr Wessenger:** I move that paragraph 5 of subsection 3(1) of the bill be amended by striking out "receiving community services" in the first line.

It's just the same amendment we've been doing with all these clauses.

**The Vice-Chair:** Any comments? If not, all in favour of the government motion? Opposed? Carried.

There's a government motion, paragraph 3(1)6.

**Mr Wessenger:** I move that paragraph 6 of subsection 3(1) of the bill be amended by striking out "A person receiving community services has the right to raise concerns or recommend changes in connection with the community services" in the first, second, third and fourth lines and substituting "A person receiving a community service has the right to raise concerns or recommend changes in connection with the community service."

**The Vice-Chair:** Discussion? All in favour of the government motion? Opposed? Carried.

There's a government motion re paragraph 3(1)7.

**Mr Wessenger:** I move that paragraph 7 of subsection 3(1) of the bill be amended by striking out "community services" in the first line and substituting "a community service."

**The Vice-Chair:** Comments? All in favour of the government motion? Opposed? Carried.

Paragraph 3(1)8, a government motion.

**Mr Wessenger:** I move that paragraph 8 of subsection 3(1) of the bill be amended by striking out "community services" in the first line and substituting "a community service."

**The Vice-Chair:** Comments? All in favour of the government motion? Opposed? Carried.

There's a government motion re subsection 3(3).

**Mr Wessenger:** I move that subsection 3(3) of the bill be amended by striking out "community services" in the third line and substituting "a community service."

**The Vice-Chair:** Discussion? All in favour of the government motion? Opposed? Carried.

Is it agreed that we postpone discussion of section 3? There are two items to be reviewed.

**Mr Larry O'Connor (Durham-York):** It's here now.

**The Vice-Chair:** A proposed revision to the Liberal motion re paragraph 3(1)4.1 is being circulated. Would someone like to read this into the record?

**Mr Wessenger:** It is hoped that Ms Sullivan would move this section, since it's in line with her motion.

**Mrs Sullivan:** I will withdraw my original motion and place this motion.

I move that subsection 3(1) of the bill be amended by adding the following paragraph:

"4.1 A person applying for a community service has the right to participate in the service provider's assessment of his or her requirements and a person who is determined under this act to be eligible for a community

service has the right to participate in the service provider's development of the person's plan of service, the service provider's review of the person's requirements and the service provider's evaluation and revision of the person's plan of service."

I think that meets the principles I was attempting to put forward, and if the wording is more congenial legally, I think it merits support.

**Mr O'Connor:** I simply agree with what Ms Sullivan said. It clears it up that a person, when they're applying for the service, is able to participate. The way the other motion was worded was kind of awkward. I appreciate Mrs Sullivan's intention and support this motion.

**Mr Jim Wilson:** I'd like to express support for the motion too, adding this paragraph to the bill of rights. I have a question with respect to this addition and its effect on section 20. I just want to know how many teeth this section of the act has. Why, if it's in the bill of rights, is it again in subsection 20(3), that we have to state again that a person has the right to participate in the plan of service? Is one just window dressing and section 20 is the actual teeth?

**Mr Wessenger:** I will ask legal counsel to clarify that.

**Ms Czukar:** The provision in section 20 is an obligation on the approved agency; it's in the section on rules for approved agencies. What that section does is state what the agency is supposed to do, and in subsection (3) the agency is obliged to give the person the opportunity to participate fully. This is the other side of the coin: This is what the person has the right to expect from the approved agency. So it's dealing with the same matter, but this is what the person has the right to expect and the other side is what the agency must do in order for the person's right to be respected.

**Mr Jim Wilson:** In terms of section 20, which I know we will get to formally, if the approved agency, or the MSA down the road, has a monopoly on the delivery of services, then it's also the service provider.

**Mr Wessenger:** That's correct.

**Mr Jim Wilson:** So why wouldn't the bill of rights talk in the same language as section 20 when it talks about "approved agency"? I know the answer may be that the service provider may not always be the MSA or the approved agency. The corollary is, why doesn't 20 talk in the same language as the bill of rights?

**Ms Czukar:** The reason is that it's approved agencies that will have the responsibility for doing assessments and determining eligibility in developing service plans. The service providers, who may be people other than approved agencies—they may be providing only one kind of service—may do their own kind of assessment and determine those sorts of things for the person when they come to them. That was why we made the wording change in the bill of rights to include the obligation on service providers who may not be approved agencies and may not have the obligation to do the full assessment and the full development of the service plan. But to whatever extent they are doing assessments as a service provider, we're saying in the bill of rights that the person has the

right to participate in that assessment and so on. It's a bit of a broader application, but it is just the other side of the coin.

**The Vice-Chair:** Any further comments? If not, all in favour of the motion? Opposed? Carried.

That completes section 3. Shall section 3, as amended, carry? Carried.

Section 4: Mr Wessenger.

**Mr Wessenger:** I recommend with respect to section 4 that we vote against this section, because this section deals with directors, and as we've now eliminated any definition of "directors" and there's no function for them in the bill, it's an unnecessary provision.

**Mrs Sullivan:** I was very interested in seeing this amendment come forward, because while directors have been removed from the bill, both in the definitions and through this section, program supervisors haven't been. Section 5—oh, yes, you have a recommendation about voting against section 5.

**Mr Wessenger:** Yes, that's the same.

**Mrs Sullivan:** The program supervisors then presumably are going to be appointed in the normal way under the Ministry of Health Act.

**Mr Wessenger:** I'll ask legal counsel to move on to that point.

1030

**Ms Czukar:** There's a government amendment coming forward under a new section 51.1 that would allow for the appointment of program supervisors, and that will be in conjunction with the inspection section, which is the place in the act where they exercise their powers.

**Mr Jim Wilson:** At this point, perhaps we could just get a brief summary of the powers of the program supervisors, that would I think be helpful, and also sort of an explanation of what you thought directors would do versus what program supervisors were to do. Under your new scheme, are program supervisors really directors just in different clothing? If that's the case, it's fine, because before it sounded like you were having two different functions and two different positions. In other words, it's a bit confusing.

**Ms Czukar:** The role of a director, first of all, was not spelled out in the act and it was inserted originally in the event that the regulations might need to assign some responsibility to a director, capital D, ie, appointed by the minister for a specific function, to exercise some function that the minister couldn't; in other words, some kind of review function or something such as we have under other statutes.

Given that it created such confusion in people's minds and we had no such function set out in the act, we decided to eliminate it, and it's therefore eliminated for the purpose of the regulations as well, but we feel that can be accommodated under the usual delegation powers of the minister.

With respect to program supervisors, as Mr Quirt pointed out yesterday in response to a question, there are existing program supervisors in the area offices who offer

a wide range of functions that include reviewing programs and so on. The kinds of powers that they might need in order to do a full inspection in the event of a complaint or something like that are set out in the act in sections 52, 53, 54, those sections, and they have to do with the ability of the program supervisor, where it's needed, to inspect the records of agencies, to inspect the premises of agencies that are providing services and ask questions of people and that sort of thing.

They're comparable to the kinds of things that compliance advisers do in the facility system. This is an accountability and a quality assurance series of provisions to ensure that program supervisors working for the ministry have the ability to see that the kinds of reports that are being filed are accurate and, as I say, to investigate complaints that are made.

**Mr Jim Wilson:** I know we're not quite at section 52, but the requirement for program supervisors to obtain a warrant was quite a discussion, as you can imagine, with advocacy and the package of bills around consent to treatment, substitute decision, but particularly advocacy. Are these powers similar or in fact a little more—my reading is it's a little more onerous in that a warrant is actually required, but under what circumstances here, for the program supervisor to be able to carry out his or her function.

**Ms Czukar:** This is a discussion of the provision in section 53, and I don't know if we want to get into the circumstances under which a program supervisor would have to get a warrant. Basically, if program supervisors attempt to exercise a right of entry that they have under section 52 to enter the business premises of a service provider or that sort of thing and they're not allowed in, they have to go and get a warrant. As I say, this is similar to what we had in the facility statutes. It's the parallel kinds of things.

**Mr Jim Wilson:** I agree that we will take a look at this when we get to the appropriate section.

May I also say, with respect to the amendment, that I'm very favourable to this trend of deleting clauses. Hopefully we can continue right through section 13 in doing that and get rid of the 80-20 rule and be happy and we can just pass the rest of the bill.

**Mr O'Connor:** I just want to speak in support of this motion. I think that as we went through the committee hearing process there was certainly some confusion around what a director was and appointing directors. There is confusion. People thought that the director referred to is director of an MSA and that the director of an MSA is going to be appointed by the minister. That's far from the truth. The reality is that it's going to come right from the community, and all these people on the MSAs are going to come from the community. That's where it needs to be coming from and it's not something to be appointed by the minister.

I support this motion. I think it's going to clarify it and make the bill itself easier to read for people trying to interpret what the legislation does in fact intend to do.

**The Vice-Chair:** That completes discussion on the government's recommendation voting against section 4.

Shall section 4 stand as part of the bill? In favour? Opposed? Agreed that it's opposed.

Section 5: Mr Wessenger.

**Mr Wessenger:** For the same reasons we're recommending voting against section 5 of the bill.

**The Vice-Chair:** Any further discussion? Shall section 5 stand as part of the bill? In favour? Opposed to it standing? Thank you.

**Mrs Sullivan:** Mr Chairman, you will recall yesterday we indicated that as a result of meetings we had with first nations people, we would be bringing forward amendments as a follow-up to those meetings. A number of those amendments appear in section 6, and I wonder if we should consider those as part of our consideration of sections 6 and 7. There would be a part in section 2 as well, which we stood down. I don't know if you want to do that now and consider them in order or if you want to consider that package of amendments at the end.

**Mr Wessenger:** Could I just suggest that we deal with those provisions of section 6 that are not relevant to first nations and then we stand down any amendments relating to first nations and section 6 as well.

**The Vice-Chair:** Is that the agreement? We have agreement of the committee then to proceed in that order.

**Mrs Sullivan:** My concern is that there are a number of instances, if I just flip through this, where if a clause is there, there would be an exemption or there would be an exception to paragraphs generally all the way through, so that in several of the upcoming sections we wouldn't be able to deal with the entire section without dealing with these amendments.

**The Vice-Chair:** In other words, if we returned to section 2 and dealt with the changes there, the motions that were stood down, then when we came to section 6 we could proceed and deal with them all in order.

**Mr Wessenger:** I think, to simplify matters, why don't we just stand down all the provisions with respect to section 6? I think the only amendments that probably will be in order with respect to section 6 will be relating to first nations in any event.

**Mr Jim Wilson:** There's a PC motion in section 6 to add (h), which is quite crucial whether you're first nations or not a member of the first nations, and that's with respect to ensuring adequate financial assistance, which I would like to deal with.

**The Vice-Chair:** Proceed with section 6.

1040

**Mr Jim Wilson:** I'd like to proceed with the PC motion in section 6, and I do agree with standing down other clauses that are relevant to the issues and concerns of first nations. I would also suggest that whenever the government is prepared to deal with their concerns and issues, it may be appropriate to have other government officials here too who are a little more aware than perhaps the Health and Social Services people with respect to other discussions between the Bob Rae government and first nations and can inform this committee of the bigger picture. Perhaps by the end of this session today the parliamentary assistant, Mr Wessenger, could

suggest what other officials might be required to be here when we have these discussions about first nations.

**Mr Wessenger:** I think it's fair to say that we will not be dealing with any matters relating to first nations today.

**Mr Jim Wilson:** But by the end of the day—

**Mr Wessenger:** I don't think we're in a position yet to look at the legal effect of the situation. I think we need more time.

**Mr Jim Wilson:** While I agree that today we won't likely get to it, perhaps you can tell us when we will; and when we do, be prepared to have other officials here on behalf of the government, because I think we'll have a lot of questions about what the broader implications are. I also want a clarification of what the current political relationship is between first nations and this government.

**Mr Wessenger:** I would suggest we deal with this at the end of the day, Mr Wilson. I think that would be quite appropriate.

**Mrs Sullivan:** I'd be quite prepared to see the amendments that we put forward with respect to first nations held over until meetings early next week. I do think that it would be useful to have additional government officials who've been working in those areas to discuss the implications.

Clearly, we had, in the course of our public hearings, testimony indicating that negotiations have been going on, that funding has been provided to first nations and off-reserve Indians and to other aboriginal organizations with respect to the development of a long-term care organization or strategy or delivery of service within and under the authority of those groups and organizations.

The concern which was put to the committee was that if there is recognition of the first nation as an independent government, if you like, the district health council role changes significantly. Certainly the promises that have been made by the government, particularly to first nations, are that they will be able to design, devise, operate and monitor their system of long-term care for people under their jurisdiction with the concurrence of the minister through an agreement that would be signed by the minister and the first nation.

I think we would be remiss not to address these issues, particularly since funding has already flowed, and that funding that's flowed is not an insignificant dollar. I don't see how the minister can operate, again by agreement, unless there is the legislative authority for that agreement or how a DHC or an MSA could be precluded from operating in, say, a first nations reserve situation unless there is some statutory change to this particular bill.

I think it would be useful for the committee to have people who've been involved in a wider sense in negotiations. This is a very practical issue for people who are first nations or aboriginals. Naturally, because it is practical, it's also a matter where there are sensitive negotiations and sensitivity in the language involved. I think this entire committee could use some extra help on this one.

**Mr O'Connor:** In trying to clarify some of this, there has been, with this government, a statement of political

intent signed between the provincial government and the first nations people that recognized their inherent right to govern. In that, we recognize that if we are going to work with them we don't place them within a legislative restriction that would not acknowledge and reflect their ability to govern their people. There's actually been work happening within the Ministry of Health recognizing their right to govern in issues like this.

I don't know whether any of the ministry officials here may actually be able to help in providing a little bit of background as to how some of that negotiation does take place. There's a discussion that recognizes their right as first nations people to have the ability to govern, and so the negotiations that do take place between ourselves and the first nations people fall under the context of the principle of that statement.

Perhaps the clerk can get a copy of that statement and circulate it. In fact, I think it was probably included in the package, in the submission by the chiefs that was given to us, which in fact puts the basic principles before us under which negotiations take place. It was part of their broader package that they had tabled with us and not the package that they had faxed to us with their concerns and the clause-by-clause issues as they addressed them, but just to help try to clarify the relationship between the present government and the first nations.

**The Vice-Chair:** The information will be circulated by the clerk forthwith. Proceed to section 6. The first is a Liberal motion respecting clause 6(c). In view of our discussion, that will be stood down, Mrs Sullivan?

**Mrs Sullivan:** The one with respect to first nations would be stood down, yes, but I do have another motion with respect to 6(2).

**The Vice-Chair:** Yes. Mr Wilson, PC motion regarding section 6 of the bill.

**Mr Jim Wilson:** I move that section 6 of the bill be amended by adding the following clause:

"(h) shall provide adequate financial assistance to ensure that the agency is able to provide or ensure the provision of the services referred to in subsection 12(1) in the geographic area for which the agency is designated."

I believe this amendment is very similar to the Liberal amendment; it's just placed in a slightly different section of the bill, which means we've used a different legal counsel, I guess. It's very important to ensure that the mandatory services referred to in subsection 12(1), which refer to the basket of mandatory services the MSA will be required to provide—groups like VON, many of its branches, made a presentation with respect to this issue.

One I wanted to read into the record very briefly was a presentation on August 18 from the Victorian Order of Nurses, Guelph-Wellington-Dufferin branch, Halton branch, Niagara branch and Waterloo region branch. They said on page 8 under the—

**The Vice-Chair:** Mr Wilson, would you mind? Mr Wessenger has something extremely important to say.

**Mr Wessenger:** Mr Chair, I'd like to ask if you could rule whether this motion is in order, because in my opinion it's a money-spending motion.

**Mr Jim Wilson:** Mr Chairman, while you're deciding, how about I continue with my debate?

**Mrs Sullivan:** I think that's a good idea.

**Mr Wessenger:** No, we should have the ruling first.

**Mr Jim Wilson:** Could I just put on the record, Mr Chairman, that this was asked for by a number of groups, not only VON, and it's an important issue. While you're deciding—

**Mr Wessenger:** But it's out of order, Mr Chair.

**The Vice-Chair:** We will make a ruling momentarily.  
1050

**Mr Jim Wilson:** That's right, but you want to hear the full thrust of the argument first, Mr Chairman.

The VON, with respect to funding, said that in the explanatory notes of the Long-Term Care Act, 1994, it states that the Health Protection and Promotion Act is amended to delete a reference to home care services under the Health Insurance Act because these services will be encompassed in the new scheme for the provision of services under the bill. It's also similar to the language contained in the explanatory note of the government's bill. This explanatory note—

**Mr Wessenger:** Mr Chair, why are we having debate on a motion before a ruling? I thought that was inappropriate.

**The Vice-Chair:** I'm allowed to hear arguments. Proceed, Mr Wilson.

**Mr Jim Wilson:** Thank you. If you want me to argue whether or not it's in order, the motion before you, Mr Chairman, is worded that they simply provide "adequate financial assistance" to ensure that the agency, the MSA, or the approved agencies are able to provide the basket of services, the mandatory services that this government says is the minimum level of services that citizens will be entitled to in this province. I can't see how that's out of order, because surely to goodness the intention of the government is to provide adequate funding.

We want to make sure there is some protection for the people of this province because, as I was explaining, as the VON and other groups pointed out to us, the government is deinsuring home care services later on in this bill. In other words, that protection provided under the Health Insurance Act is being removed from home care services. It's a delisting, which will be about number 20 this government's delisted in terms of services under OHIP. In other words, you're gutting medicare.

By gutting medicare in this act with respect to home care services, we need a clause like the one I'm suggesting to ensure that citizens have some financial protection, that the government will provide the assistance. That's the general intent of this thing, and the word "adequate" is in there to ensure that the government provides adequate assistance.

**Mr Wessenger:** It is imposing an obligation on the government to spend money, and that's certainly a matter that's out of order.

**Mr Jim Wilson:** Are you going to provide these services for free? You have an obligation to spend money anyway. I thought the rule was more about imposing an

obligation to spend additional money that isn't contemplated in the act, and I'm not asking for that. I'm asking to ensure that there is a legal remedy in here so that if they don't provide the services adequately throughout the province, citizens can come after them under the act and have some legal protection. They're making another historic move here by deinsuring home care.

**Mr Wessenger:** We're not deinsuring in the sense of—

**Mr Jim Wilson:** Your own explanatory note in the bill says you are deinsuring home care. So what is it?

**Mr Wessenger:** We're providing another way of financing it. We're moving to a—

**Mr Jim Wilson:** You are taking it out of the protection of the Health Insurance Act and putting it into an act that you now tell me you won't even allow a financial clause in to ensure that financing for these programs is ensured.

**The Vice-Chair:** Thank you, Mr Wilson. Mr O'Connor, did you have a comment before I make the ruling?

**Mr O'Connor:** In your weighing of this decision, and having an opportunity perhaps to enlighten my colleague, there has been a huge commitment by this government in terms of funding for long-term care. In fact, since 1990 there's been a 54% increase, and funding in long-term care in our community has seen an increase from \$550 million to \$850 million this year. There is a commitment not only in words but in dollars. The money is flowing. There are people employed in providing all these services.

I realize the intention my colleague has: wanting to see the programs continue. You have that commitment not only in word but in deed by this government. He's nervous about future governments—perhaps that's the concern he's got—but unfortunately it's not within his rights as a member to direct funding by the government. I would suggest that the motion is out of order because he's trying to direct funding.

**The Vice-Chair:** Thank you, Mr O'Connor. I'm glad you added that at the end, because indeed it would be speaking to the matter of whether it is or is not in order.

At this time I'd like to read section 56 of the standing rules:

"Any bill, resolution, motion or address, the passage of which would impose a tax or specifically direct the allocation of public funds, shall not be passed by the House unless recommended by a message from the Lieutenant Governor, and shall be proposed only by a minister of the crown."

As this does indeed direct the allocation of funds of some amount in some regard, I rule that the motion is out of order.

**Mr Jim Wilson:** Mr Chairman, could I ask you a question? I'll accept your ruling, of course, but I think I'm allowed to challenge it.

What provision, then, do citizens of this province have when the government deinsures a service? When we get to the section of the bill that says home care will no

longer be part of the Health Insurance Act and that the new scheme for funding home care is supposedly encompassed in this act—the opposite to your ruling would be, what if the government is doing something against the best interests of the citizens of this province in terms of deinsuring a service?

How do we as parliamentarians address that if we can't compel the government, in any way, to live up to financial obligations that supposedly it's making under this act?

I don't find it acceptable to simply have Mr O'Connor's word that sufficient amounts of money will be provided by the government to ensure that these services its legislation requires will be up and running across the province. What is the legislative remedy for that, and do opposition members or ordinary members of the Legislature have any course they can pursue? I would like your advice on that.

**The Vice-Chair:** I don't think I'm in a position to advise on that, and that's beyond the matter of this ruling, in my opinion. This is an iffy case, but in following the standing order I've made the ruling. And I do think, Mr Wilson, that you know some of the ways in which the government—

**Mr Jim Wilson:** Can be compelled.

**The Vice-Chair:** —can be requested or persuaded to change its views on some matters. In view of that, we'll proceed—

**Mr Jim Wilson:** But organizing those demonstrations is just taking too much of my time.

**Mr Wessenger:** I think Mr Wilson's comments are out of order. We should proceed to the next motion.

**Mr Jim Wilson:** Hey, who's chairing this meeting, the parliamentary assistant?

**The Vice-Chair:** All seem to be helping, and it's greatly appreciated.

The next is a Liberal motion regarding section 6 of the bill.

**Mrs Sullivan:** I move that section 6 of the bill be—

**Mr Wessenger:** Mr Chair, if I might make a point of order.

**Mrs Sullivan:** He can't rule it out of order till it's read in, sir.

**The Vice-Chair:** Proceed, Ms Sullivan.

**Mrs Sullivan:** I move that section 6 of the bill be amended by adding the following subsection:

"Funding of mandatory services

"(2) The minister shall provide a multiservice agency with financial assistance that is sufficient to enable the agency to provide the services referred to in subsection 12(1), or to ensure their provision, in the geographic area for which the agency is designated."

This motion is put forward to ensure that those services which are mandatory and required in every part of the province under the bill, a concept we believe in because it will ensure that there is equity and equivalency in services that are available, are in fact funded. The bill is very loosey-goosey in that it now enables the minister

to "may provide" financial assistance. There's no guarantee that that financial assistance will flow.

**Mr Wessenger:** Mr Chair, I'd like to make a point of order that this is similar to the previous motion in that it involves spending of money and is also out of order.

**The Vice-Chair:** I rule that the proposed motion is out of order.

**Mr Jim Wilson:** Mr Chair, may I just ask a question? Perhaps it's directed to the clerk of the committee, through you. Is there any way we are allowed to discuss the question of financial resources behind a piece of legislation?

**The Vice-Chair:** I think, Mr Wilson, that in this case we've certainly had more discussion than would normally be permitted. We have indeed discussed the matter quite thoroughly, as a matter of fact, so thank you.

1100

**Mr Jim Wilson:** That's a very polite scolding, Mr Chair.

**The Vice-Chair:** I'm learning.

I require committee agreement to stand down section 6.

**Mr Wessenger:** Agreed.

**Mrs Sullivan:** I have another motion to section 6.

**Mr Wessenger:** That's a new section, Ms Sullivan; it's a different section.

**The Vice-Chair:** We'll proceed to that next. So we have agreement to stand 6 down?

**Mr Jim Wilson:** Agreed.

**The Vice-Chair:** Thank you. Next is a Liberal motion regarding section 6.1 of the bill.

**Mrs Sullivan:** I move that the bill be amended by adding the following section:

"Insured services

"6.1 Nothing in this part shall affect payment under the Health Insurance Act for any community service that is an insured service within the meaning of the Health Insurance Act."

This motion is put forward—

**Mr Wessenger:** Mr Chair, could I raise the question that this also involves an obligation on the government to spend money and would also be financial and out of order.

**Mrs Sullivan:** No. Mr Chair, in my view, this is not a spending motion; it's a matter of guaranteeing that those services which are now covered by OHIP, by medicare, those services which are medicare services, will continue to be covered under medicare. To understand the argument about why this is not a money motion, I think one has to understand the context: that services which had been provided in facilities and guaranteed under the Canada Health Act and through the Ontario Health Insurance Act will now be provided in a different setting, in a community agency that's located in a community or in a home.

**The Vice-Chair:** Thank you, Ms Sullivan. I'm prepared to give my ruling. The ruling is that it will stand, it is not out of order, because it does not specifically

direct the allocation of funds. You may proceed.

**Mr Jim Wilson:** Well done, Mr Chairman.

**Mrs Sullivan:** This issue is one that has been raised throughout the hearings and is one we are concerned about, with respect to the adequacy of the thinking behind the financing arrangements.

On a daily basis, more and more activity is moving out of facility-based institutions—whether it's hospitals, whether it's homes for the aged, whether it's other sources that have received coverage under the Health Insurance Act—into new settings. Those services are guaranteed as part of medicare under the Canada Health Act, and in order for Ontario to qualify under the Canada Health Act for transfers, it has a Health Insurance Act which guarantees the coverage of those medically necessary services.

Unfortunately, many of those services are limited in their coverage to the place where they're provided, and what we want to absolutely ensure is that those mandatory services which are now insured services under the Health Insurance Act are covered under that act, under medicare; that we are not losing anything under medicare because of the place or the nature of the service delivery by which they're provided.

We think this is a fundamentally important amendment. It goes to the heart of medicare and what people's expectations are, and should be, for full coverage: their right to full health care under this or any other act.

This bill, as you know, brings together an integrated approach to health and community services. Those health services which will be delivered in the home now may well include dialysis, may well include other services, physiotherapy services. In the mandatory basket we see a number of areas which would now be covered by OHIP and may well not be covered by OHIP under this bill.

We're saying there ought to be no change, that the same guarantees ought to exist. Any health services provided under this bill should continue to be considered a part of the right of the individual to health care which we have agreed upon, as a nation, as part of medicare.

**Mr O'Connor:** This is a very interesting discussion, which I believe is probably out of order, but you've ruled and I appreciate your ruling.

The fact of the matter is that all parties agree on the fundamental principles of medicare. Other parties in Ottawa haven't always treated its importance the same way. In fact, we see a huge discrepancy for Ontario because of the cap placed on the Canada assistance program, which flows the moneys through for that very important principle in which we all believe, by a previous government, and now the present government continues that. We could certainly have an interesting argument around this.

I'm pleased that the member mentioned, in her discussion around long-term care facilities, homes for the aged. Homes for the aged weren't funded by the Ministry of Health, as we all know, but funded through the Ministry of Community and Social Services; they weren't covered by the Health Insurance Act. The people who stayed there in effect got more—there was more funding flowed per person in homes for the aged than there was

in the nursing homes. So it's rather incredible to hear that the only way somebody's going to have these services ensured is if they put it under the label of the Health Insurance Act. The fact is that there's been more funding going into areas that aren't covered by that, so I find it incredible that they want to place limitations: "Let's place a limitation on it so it's only covered by that."

This government, as I said before, has made a huge increase in payments to the community side in long-term care reform. We've made a financial commitment there that is in place, and it is happening. Now we hear arguments saying, let's put some limitations on it. Let's maybe limit it to the amount the federal counterparts of my colleagues opposite like to limit ours by. Instead of 50% funding, in the true sense of medicare we always participated in, it's down around the 30% mark now. It's ridiculous, and now they want to place a further limitation on it.

I think what's missing here is that the principle behind this long-term care reform is that we're going to a new method, an envelope funding method, and that method doesn't gel with the Health Insurance Act. People still think of OHIP as a premium insurance plan. It's something different; the two don't mix the same way. For them to sit in their places and say we're going to see less services and that services to seniors are going to be eliminated and cut out by this government—well, nothing could be further from the truth. A 54% increase certainly does show a huge commitment by this government.

Though I wish you had ruled it out of order, Mr Chair, I'm glad we've had a chance to have this discussion. The fact is that the method for funding in this fashion—the two don't relate well.

My colleagues may want to ask the question why, and they're certainly able to do that when they have an opportunity to speak, but the fact is that the homes for the aged weren't funded through the Health Insurance Act, but they were there. We finally improved the funding formulas there through our last round of long-term care reforms.

This is dealing with the community side, and it doesn't flow in the fashion they remember things flowing. It's going to be planned so that the community has far more involvement, and it involves consumers in coming up with the plan for the services needed within the community. It's certainly going to be more responsive to the needs of the consumers.

I appreciate the motion and the intent. We certainly don't want to see any services being cut to seniors, and we've increased them far more than any other government in the past, so I appreciate that as well. Her intentions are fine and honourable, though I think she's maybe somewhat confused about the funding methods by which the funding will flow. I appreciate it, but I won't be supporting this motion, and I won't recommend it to my colleagues either.

1110

**Mr Wessenger:** I'd like just to reiterate the point Mr O'Connor made. First of all, whether you have it technically under an insurance system or whether you have an

envelope funding system, the basic question is how much money goes into the service, not the question of which system you use. Second, if anything, Ontario is slow with respect to moving to an envelope funding system with respect to home care in the sense that every other province except New Brunswick has already moved to an envelope funding system.

This is in line with the fact of what all the provinces are doing. I'm surprised that the opposition party—I always thought they supported a managed health system. Certainly that's the move that's happening all over the world, managing the health resources effectively. That's why we oppose this motion, because we think the envelope funding method is the most effective way to manage the health resources.

**Mr Jim Wilson:** It's a very interesting discussion we're having here with respect to funding methods, because it was never really clear exactly how the government was proposing to fund the MSAs and the services they must provide. I also find it passing strange given that you've rejected some PC motions that talked about needs-based planning. How are you contemplating developing and discovering the needs of each of the MSAs so that you can provide them with an envelope of dollars? I'd like at this point to hear a little more about the planning that's going into the method of funding.

Secondly, just with respect to Mr O'Connor's comments that this motion might in some way limit the dollars that are to go into home care services, clearly the intent of the motion is to ensure that citizens can be guaranteed, as they are under the Health Insurance Act scheme, that home care is an insured service. I would remind Mr O'Connor that the only reason that he could see a conflict in this motion or that he could come up with the argument that this motion might in some way limit home care funding is because of the caps on OHIP.

It's your own policy, and that policy may not always be in effect in this province. That's your deal with the OMA at this point. There will be, I assume, a new government in a few months and that may not always be the approach of government. Therefore, I guess, is it necessary for you to deinsure home care services at this point, given that I would say that the funding scheme in the future is very much going to be left up to another government? As a citizen of this province, I would feel much better having home care guaranteed under the Health Insurance Act, given the uncertainty of the funding models that may be used in the future.

**Mr Wessenger:** I'm going to ask the policy adviser, Mr Quirt, to indicate some explanation of the funding mechanisms, because you have specifically asked that question and I think it's a legitimate question to be asked.

**Mr Geoff Quirt:** Just to clarify, the Canada Health Act does not require provinces to deliver long-term care services as a health-insured service. As Mr Wessenger has pointed out, there are two provinces that still deliver community-based long-term care services as a health-insured service: Ontario and New Brunswick.

You'll recall that the passage of Bill 101 in effect altered the way in which long-term care facility services were funded in Ontario. Rather than residents of nursing

homes being insured policyholders under OHIP and having funding to nursing homes go through the Health Insurance Act, we introduced a direct contractual relationship with both homes for the aged and nursing homes and we no longer fund nursing homes or homes for the aged under the Ontario Health Insurance Act.

As Mr O'Connor pointed out as well, ironically it was the formerly insured programs that received the lion's share of \$206 million in additional funding. There certainly wasn't a connection between being insured and being well funded under the facility system.

With respect to the community system, just to clarify, not every province is moving towards an envelope funding system. As a matter of fact, our envelope funding system as proposed for long-term care is—

**Mr Jim Wilson:** Pretty unique.

**Mr Quirt:** —I would argue moving towards equity at a faster rate than many of the other provinces.

**Mr Jim Wilson:** Whatever equity means.

**Mr Quirt:** Well, equity doesn't mean our current situation where some communities in Ontario have four times as much spent on community-based long-term care services per capita as others: Renfrew and Ottawa at one extreme and Niagara at the other. The equity funding formula is designed to measure the requirement for community-based long-term care funding based on a number of factors. The primary factors are how many people have to be served, their age, their sex and their likelihood to consume long-term care services.

In addition, the envelope funding formula we're employing has two other factors. While roughly 90% of the new funding will be distributed on an equity basis, in other words, those people with the smallest share of community-based funding will get the largest amount of the new \$441 million in community service funding, 10% of the money is distributed on a population basis. So even those communities at the top end and relatively well resourced for community service funding will receive some new funding to allow them to work through the transition to the new multiservice agency system.

In addition, \$10 million has been set aside starting in 1995-96 to recognize the difficulties inherent in delivering services in an area with a high percentage of elderly people in what the federal government determines as rural settings. In other words, if you've got problems associated with population density and travelling distance, there's a factor built into the formula to try to address some of those extra costs.

In effect, what we did about two weeks ago was give each of the district health councils across the province a planning target that lets them know how much money the government's committed to spend by 1996-97 in long-term care in their area. For some communities, it's a very sizeable increase because they didn't have their fair share starting out. In other communities, there's a very modest increase when they were relatively well resourced prior to the reform.

While \$441 million in new funding doesn't allow us to achieve total equity, we move a great distance towards equity with the funding formula. In order to achieve

equity, we'd have to take some money back from those communities that are relatively well funded now and distribute it elsewhere. We're not doing that. We're keeping those communities at the level of service they're currently experiencing and providing a modest increase in terms of 10% of the funding being distributed on the basis of population alone. But the majority of the money addresses the inequities in the funding level currently. We're hoping that DHCs very soon will be giving us not only their MSA plans but their multi-year plans for how they wish to spend that additional money that's committed to them up until the end of 1996-97.

**Mrs Sullivan:** Mr Quirt is quite right that the Canada Health Act does not require long-term care services to be covered. The Canada Health Act, however, does require medically necessary services to be covered in each province. The traditional method in Ontario by which that has been done is through the Ontario Health Insurance Act, where services which are provided in hospitals and those provided by medical practitioners and some other professionals are covered under OHIP.

Because many of those services which have been provided in the past in hospitals or in settings where the clinical services are provided as insured services will now be provided in a different place, the funding envelope may—I should say that I think a funding envelope system is an interesting and forward-looking approach, but within the context of that funding envelope system there must be a guarantee that those medically necessary services which are now being delivered in the home or down the street, where a Wheel-Trans van can take a patient, by example, are covered in the same way that other medically necessary services are covered. In other words, there should be a guarantee that there will be no change to the insured coverage of medically necessary services because they are provided in a different context and perhaps by a different deliverer.

## 1120

Dialysis is a perfect example. Over the past six years dialysis has moved out of the hospital setting in many, many cases into either regional centres or homes. In many cases the dialysis is a self-care situation where, beyond the training that's provided by a specialist nurse, the services are for the most part provided by the patient and the patient's personal attendant, who usually happens to be a spouse or a child. In those circumstances, there are still costs attached with that. Oxygen therapy is covered under a different program, but there's no guarantee that oxygen therapy may well still be covered under this act.

I feel very strongly that there must be a guarantee in this bill that those medically necessary services, which are a part of medicare and included in the Health Insurance Act, are guaranteed in this bill. Otherwise, why would anybody stay at home? If you can be absolutely assured and guaranteed that your service will be ensured if you're in the hospital or in a doctor's office, why be at home when you're not sure you're going to get the coverage that you need to the full extent that you need it, given the therapeutic decisions and determinations about your own case?

Envelope funding, I agree, is a step forward. My own view is that we probably need a separate piece of funding legislation that will put envelope funding in a different plane than it exists in now, where it's sort of a program funding of the minister rather than a statutory arrangement. But I couldn't be more adamant that those services which are part of medicare must be guaranteed under this bill.

**Mr Jim Wilson:** I think the motion on the table speaks to the disturbing trend that we're seeing across all provinces, and that is the delisting of medically necessary services. It's one of the giant loopholes that you can clearly drive a truck through in the Canada Health Act, and it's being conveniently used by a number of provinces.

I appreciated very much Mr Quirt's explanation of envelope funding, and also his comment that Ontario is moving towards equity faster than any other province. I would add, though, that the people of Ontario are losing their guarantees under the Canada Health Act faster than any other province too. This'll be the 20th or 21st delisting of an insured service.

Yes, when the Canada Health Act was brought in in the late 1960s, the federal government, rather than get into a debate with the provinces, simply said, "Whatever you're doing now in your health insurance plans or whatever services you're providing now in your hospital settings, when we develop the health insurance plan, we will deem all of those services medically necessary services."

What happened then and what's happened since is twofold. One is the federal government is sending less cash to the provinces and in other areas, particularly the portability clause, is not enforcing the Canada Health Act.

I think of the snowbirds issue right now, which, by the way, is only one part of that issue surrounding this government's refusal to live up to the portability clause, surrounding this government's refusal to support families and children and senior citizens who find themselves sick or in an accident outside of this country. This government, along with other provinces, is simply ignoring that provision of the Canada Health Act which says that you must provide the same dollars that you would normally have provided should that person have got sick or in an accident in Ontario.

Those provisions are being ignored, and the vast amount of people who are being hurt by that are not snowbirds, although that is the group that has come to take the government to court on this issue. My understanding is that only about 25% of out-of-country payments are for senior citizens; 75% are for children, are for people who are driving down I-75 and get in a car accident, the family ends up in hospital and this government refuses to pay any more than \$100 a day for each of those family members, or people who break their legs on a ski hill in Colorado.

I think the rest of the province should wake up and not just allow snowbirds to carry this issue, because it's clearly against the law. The federal Liberal government is guilty of not enforcing the Canada Health Act and this government is guilty, along with other provinces, of not

enforcing the Canada Health Act.

What this motion on the table speaks to is a similar principle, and that is that, once again behind closed doors, the government is trying to delist a service. I don't think that's an appropriate way at all to go about reforming Ontario's health care system. If we have problems with the Canada Health Act, then why don't you do what Quebec did prior to the last federal election and challenge the federal government to open up the act and have a frank and open discussion with Canadians about the act? Because user fees are creeping in at an alarming rate in our provinces and in our services across this country, and nobody seems to want to deal with that, mainly because the Canada Health Act is essentially mute on the issue of user fees if you deinsure the service first.

A minor but important example would be circumcision, which used to be provided under the act, or repair of torn ear lobes, which used to be under the act. Removal of port-wine stains for certain age categories used to be insured under the act. There are some 20-odd, I believe, things that have been deinsured by the NDP government.

**Mrs Sullivan:** They had a broad public consultation too, didn't they?

**Mr Jim Wilson:** Yes. As Mrs Sullivan quite correctly points out, the public consultation consisted of one afternoon, by invitation only: You could appear and tell the government that you didn't like this way of reforming Ontario's health care system.

Those are 100% user fees. Now people who used to have those services paid for under OHIP must pay 100% for those services out of their own pockets. There was no public discussion. It was, pull the wool over the eyes of the public. The trend is very disturbing and that's what this motion speaks to.

Our preference, with our Common Sense Revolution, has been to stop this nonsense and to stop pulling the wool over the public's eyes. Mr Harris and my party are very much committed to reversing this trend. We're supportive of this motion by the Liberal Party today because it's an attempt to also try to reverse this trend of deinsuring services.

I don't think you should be allowed to simply say, "Well, today we pay for a certain service under OHIP and tomorrow we don't," without having a frank and open discussion with the public of this province about the way that you're going.

With that, Mr Chairman, I appreciate your allowing this motion to stand and I appreciate the debate that we've had. I think it's an important point that the people of Ontario have to understand, and that is that in the guise of reform there's a lot more happening that I think sets some pretty dangerous precedents for the future of medicare in this province.

**Mr Wessinger:** I think it should be made very clear that this act in no way overrides the Canada Health Act, because I think it was made very clear by Mr Quirt that there was nothing in the Canada Health Act that required home care to be provided.

With respect to the whole question of medically necessary acts, the appropriate act that deals with that is

not the Long-Term Care Act but the Health Insurance Act. That's the vehicle which determines what is the medically necessity, not this act. We're really having a discussion beyond the scope of this particular act, and even with respect to this particular amendment, because if we're really dealing with the question of medically necessary acts, that's under the Health Insurance Act as far as the provincial jurisdiction is concerned.

**Mr Jim Wilson:** I think you missed the point totally, Mr Wessenger.

**Mr O'Connor:** I appreciate the opportunity to speak and perhaps address a few of the concerns raised by my colleague across the committee room. The reality is that there haven't been any cutbacks in long-term care dollars by this government. Let's spell out the realities. The myths can be perpetuated by my colleagues, but the reality is that in 1990-91, long-term care community funding was \$550 million in this province. This fiscal year it will be \$850 million, a 54% increase. Next year it will be over \$1 billion. The commitment has been made by this government to provide adequate dollars, given the days we live in. We are living in a most difficult period, unsurpassed since the 1930s, in this province of Ontario, and we've had to deal with this.

1130

In trying to deal with this in the most comprehensive fashion possible, we're moving long-term care dollars. We're moving the services, yes, from out of the OHIP system, putting them into a far less bureaucratic system, one that's going to provide for local accountability, more responsive community envelope funding to take place. If there's anything that we want, we want to have more accountability. What we're doing is taking that accountability away from the bureaucracy—not that they don't do some good stuff—and putting it right into the community. I don't think that's a problem.

If we were to talk about all the numbers of programs that we have within what we call the health care system here in Ontario—let's take a look at the assistive devices program. This year, 135,000 people are going to gain from that program. This year, \$84 million is going into that program. You don't go through a process of reform without actually changing things. Things do change. The program is very rigid the way it's set out today; it's cumbersome, it's confusing, it's not responsive to the community. We're trying to make it more responsive. There's a commitment by the government to put increased dollars in there. In fact, the dollars have been flowing.

I've talked about the huge commitment we've made. I've expressed how much in real dollars and cents we've placed forward. All we could ask from them perhaps is a commitment that they're going to make sure the dollars continue to flow. Maybe they could even respond to their colleagues in Ottawa to not continue the regressive practices of past governments in not flowing adequate dollars through to the province. That would be a better way of trying to deal with this situation, given the reality of today, but that's not what we're hearing.

Long-term care in the community and reform around the community side of this has to take place within the

community. It doesn't take place in the rigid rules as laid out through the home care as we see it today, the \$100 million for Metro home care. You can't tell me that isn't a bureaucracy, because it is, and it doesn't necessarily offer the most flexibility to consumers that is required.

What we're trying to do here now is to make sure that it is as accessible as possible, as accountable—locally accountable. Local accountability I think is a hallmark that should be looked at here. The dollar commitment is made. The province of Ontario, the NDP government of Ontario, has made a 54% increase. Spending this year on long-term care on the community side is going to be \$850 million. It's real. It's there. The commitment's made and it's happening.

Talk about deinsuring things. You put out there a lot of fears that don't need to be put out there—shameful practices—but it's unfortunately part of the political process that we have in this Legislature and that spills into our committee rooms. The reality is, the dollars are there. The government has made a commitment. It's happening. We probably would not even need to have this discussion if the ruling was done the way that I thought maybe it should have been, but the reality is—

**Mrs Sullivan:** Are you challenging the Chair?

**Mr O'Connor:** The reality is that—

*Interjection.*

**Mr O'Connor:** You ruled, and I certainly wouldn't want to challenge that. The fact of the matter is, when my colleagues go out there and put all kinds of accusations—

**Mr Jim Wilson:** We're reflecting what we heard during the presentations.

**Mr O'Connor:** —and rhetoric in what they'd like to think they have heard—in fact, no doubt that they have heard—

**Mr Jim Wilson:** The Ontario Coalition of Senior Citizens' Organizations said the same thing.

**The Vice-Chair:** Please.

**Mr O'Connor:** —and it almost seems in a time that what they're doing—

**Mr Jim Wilson:** Citizens for Independence in Living and Breathing said the same thing.

**The Vice-Chair:** Please. Mr O'Connor has the floor.

**Mr O'Connor:** The fact of the matter is—

*Interjection.*

**The Vice-Chair:** Order.

**Mr O'Connor:** Thank you, Mr Chair. You know, my colleagues like to point out falsely that there have been cuts—

**Mr Jim Wilson:** That's what we're telling you. I hope you understand it.

**Mr O'Connor:** They're trying to say there have been cuts. The reality is that there haven't been.

**Mr Jim Wilson:** Removing the guarantee is what we're saying. Address that issue.

**Mr O'Connor:** The \$850 million is far better than any piece of paper saying we've got a guarantee. You've got a commitment in action. We didn't have that commit-

ment in action from other people who fund dollars down through us to flow to the health care system that we need to maintain here in this province. I wish we could have got that type of rhetoric, not in just a form of rhetoric from my opposition colleagues but in real commitment by their parties in Ottawa, but it didn't happen.

But this province has made a commitment to the continuing health care of the people of Ontario, in not just a rhetorical sense but in dollars and cents. It's happening; over \$1 billion next year. I think that's a huge commitment that will allow us to continue to provide the health care that people expect, with consumers and the community being the recipients and being involved in the process as close to the locality as possible. So again, I'm not going to advise my colleagues to support this section. I just wanted to put those points on the record.

**Mrs Sullivan:** I'd like to go back to regulation 452, section 44, of the Health Insurance Act, which provides now the accommodation for funding for home care programs, whether provided by a facility or an agency which is approved by the minister to provide home care services. The home care services that are included in that regulation include; services that are provided on a visitation basis by a nurse or nursing assistant; services provided by a homemaker; services provided on a visiting basis by a physiotherapist, occupational therapist, speech therapist, social worker or nutritionist; provision of dressing and medical supplies; provision of diagnostic and laboratory services; hospital and sickroom equipment; transportation services to and from the home to a hospital, health facility or the attending physician's office, as the case may be; and the provision of portable meals.

In that same regulation, the homemaker is defined, the nurse is defined, the nursing assistant is defined and the professional service is defined. The conditions for the payment of those services are defined.

One of the things that is going to be changed that's a positive change under this new bill is that the applications don't have to go through a medical doctor to ensure that services are provided, which was the case with home care. None the less, there is a significant difference between the mandatory services that are provided under this bill and services which are insured under OHIP.

The professional services, including nursing, physiotherapy, occupational therapy, speech-language pathology, nutritional services that would otherwise be insured under OHIP, will not be insured under OHIP; they will be mandatory services. There may well be funding under the envelope funding that's provided. There's no guarantee that the funding that's coming to the MSA will be fully appropriate for all of the medically necessary services provided in context and in a place that is other than the hospital or a clinician's facility.

This regulation in the Health Insurance Act with respect to home care isn't there for naught. It's there for a purpose: to ensure that services which are provided in the home which are medically necessary services are considered to be insured services under medicare, even if they are not provided in a hospital or other facility site. That's why the regulation is there.

What we are saying is that the same guarantee of the

existing regulation should apply within this act to medically necessary services and those ancillary services to those medically necessary services that are provided in a setting that is other than a hospital or institution.

This reg will go by the boards. Regulation 44(4), or 44(1), will go by the boards when this act comes into force. What I'm saying is we need an amendment, and I have put forward such an amendment, that will ensure that those medicare services that are now insured under OHIP that will be lost as a result of the change in this regulation are included in this bill. This is the way to do it, and I urge your support.

1140

**Ms Jenny Carter (Peterborough):** I think we're kind of getting things a little bit confused here, because whether something comes under insurance or not, it's still ultimately dependent on the amount of money that is made available by the government in office at the time. So even if you have these nominal rights, if the money just isn't there, the bureaucrats who have to administer the system are going to tighten up the eligibility, they're going to do something, they're going to scale down the services, so that although you may nominally still have those services, they will not be what in the spirit of the legislation originally they were supposed to be.

As I look around Canada at the moment, I see threats of considerable reductions coming from the federal government. I see a dwindling transfer payment for health services coming through. There was a formula that was put in place by the Mulroney government that means that amount gets less as the years go by. I haven't seen the Chrétien government do anything about that.

Really, the bottom line is whether you've got governments in power that are going to budget sufficiently for health care or not, and if you haven't, the public is going to suffer whatever the framework, whatever the system under which that money is being distributed. As Larry has said very clearly, this government has shown its goodwill by actually putting the money forward, and to leave things under insurance doesn't really guarantee anything if we have governments in power that do not have the real will to make sure those services are adequately available to the population.

If we look at Alberta right now, I guess they come under the same federal legislation, but I think there are some really appalling things happening there as the result of the slashing that has taken place in health care and other systems.

I'm going to a seniors' rally at lunchtime today. There are seniors in this community and I guess all over the province who are getting very concerned and very scared, and I think the chief source of their fear at this moment is what is going to happen at the federal level as cuts take place there.

Of course, historically it is the NDP that has introduced health care, which was opposed at every turn in the early days. It is part of our philosophy that community-based systems which are answerable to the consumer should be in operation. I think in our hearings on this particular bill we have seen that members of the other

parties are particularly liable to be influenced by present representations from providers, who are an important part of the system, but what we're really looking at here is providing the best possible service to consumers, and I think that is what we're doing.

**The Vice-Chair:** The Liberal motion is before us. All in favour of the Liberal motion regarding section 6?

**Mrs Sullivan:** Recorded vote, please.

**The Vice-Chair:** Recorded vote. In favour?

**Ayes**

Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Carter, Malkowski, Martin, O'Connor, Rizzo, Wessinger.

**The Vice-Chair:** Motion lost.

Section 7, PC motion re clause 7(1)(b) of the bill.

**Mr Jim Wilson:** I move that clause 7(1)(b) of the bill be struck out and the following substituted:

"(b) the agency is or will be operated in compliance with the bill of rights set out in section 3 with competence, honesty, integrity and concern for the health, safety and wellbeing of both the persons receiving the service and the service providers."

The reason for wanting to replace the government's wording in clause 7(1)(b) is twofold: One is that we want to ensure that there is some connection between this section of the bill, in terms of the minister's requirements in coming to approve an agency, and the bill of rights. We want to make sure there are some teeth in the bill of rights, so we've sort of cross-referenced the bill of rights into this section to ensure that when the minister is approving an agency, she or he must take into account the ability of that agency to comply with the bill of rights. Right now we feel that the bill of rights is sort of standalone and it's very unclear under this bill as to what recourse, easy recourse, the public would have should there be a violation of the bill of rights. So we're trying, during the formative stages of agencies and their approval, that there be a requirement that they operate in compliance with the bill of rights as set out in section 3.

Also, the latter part of the motion speaks to "concern for the health, safety and wellbeing of both the persons receiving the service," which is the government's wording, but we also add service providers, because groups like the District Health Council of Hamilton-Wentworth, for example, in its presentation I thought made a very compelling argument that rights in our society must go both ways and that you can't or shouldn't just here be ensuring the rights of consumers or the people receiving the services but that service providers have some rights too. There's an attempt here to link that, which we think is fundamental.

I would hope the government can accept this amendment. It varies slightly in wording, although significant in content, from their own clause 7(1)(b), but I think, upon giving it some thought, the government should be able to if it really wants the bill of rights to have any teeth and if it really wants to protect the rights of service providers

and those receiving the services, the consumers.

I also want to add, one of the groups, Cheshire Homes of London Inc, asked specifically for the compliance provision that's set out in the first part of this motion.

**Mr O'Connor:** I appreciate the opportunity to speak to this PC motion. I appreciate it, and I'm looking at it and trying to relay it through the balance of the act.

In the majority of this act, we're trying to deal with the consumers, the needs of the consumer, the person to be receiving the service, and I wondered if my colleague might not consider a friendly amendment with regard to the service providers, because basically the bill has been directed at the consumer. Given the nature of the legislation is directed at the provision of the service and the person receiving this service, I wondered if the word "both" and the end of "service providers" might not be seen as a friendly amendment that would keep intact what he's suggesting and yet I think flow better with the legislation itself, which is primarily directed at the consumer itself. I guess I would have to probably ask for some legal counsel advice and then look to my colleague whether or not that would be seen as a friendly amendment as well.

**1150**

**Mr Wessinger:** Legal counsel would like to make some explanation here before I get into this, so I'll ask for explanations from legal counsel.

**Ms Czukar:** If I heard the proposed amendment correctly, it's to eliminate "and the service providers" at the end. Is that correct?

**Mr O'Connor:** And the word "both."

**Ms Czukar:** Right. I'm advised by legislative counsel that we would need an "and" after "section 3" and in that case it would not be inconsistent. This is not the place where we envisioned putting compliance with the bill of rights.

Of course, under the provisions around section 44 with respect to revoking approvals and so on, the approval of an agency that's given under this section could be revoked if the agency is not complying with the act or the regulations and the bill of rights is part of the act. That is incorporated anyway, so it's not necessary here in terms of a power to be able to revoke the approval. But it's not in conflict with the other provisions in the bill, so it could stand.

**The Vice-Chair:** Did you wish to comment then, or will we move on?

**Mr Wessinger:** I'm just going to say I personally feel that it's unnecessary and redundant, particularly with reference to the approval of an agency. It's like saying, "We'll put in every condition that relates to what action can be taken if an agency breaches the act." It's like putting into the bill of rights the more general "We'll only approve it if you think they're going to comply with the law." I don't know whether that really is appropriate to put into a motion.

**Mr Jim Wilson:** May I just respond before Mrs Sullivan has an opportunity to speak? With respect to Mr Wessinger's comments, I'm rather baffled, because I was actually sort of appreciating Mr O'Connor's comments.

You two really should get together once in a while. The fact is, your wording—

*Interjection.*

**Mrs Sullivan:** But who had the lead on the bill? Someone should be reminded.

**Mr Jim Wilson:** It's a family feud. Your wording of clause 7(1)(b), to me, and I expressed this during the public hearings, is too airy-fairy. We're talking about things like honesty, integrity, competence as a basis for approval. To me, you need to link that clause, beyond just subjective concepts like honesty, integrity and competence, to your own bill of rights, with which you went to a great deal of effort. We support the bill of rights and we were able, I think, to improve it somewhat yesterday through an amendment. You've got to link it here so that there's a little more teeth in this section.

I will say that if one of the conditions of government acceptance is to remove "and the service providers" from the end, a reference to service providers, I would agree. Although I do feel very strongly about it, I will take a half-victory in at least including the bill of rights here, which I think is very, very important, and we'll probably try and address the concerns of service providers then, and their rights, at some other appropriate point in the bill, if we can. I'll just leave it at that.

**Mrs Sullivan:** We have later, to clauses 41(c) and 43(d), placed amendments—I have to speak to them now as we discuss this one—that would add a right to the minister to step in where the agency had acted in violation of the rights afforded a person under section 3 of the act, under the bill of rights. I think that may well be a more appropriate place to ensure that the agencies are operating and understand their obligation under the bill of rights in terms of dealing with people.

I was very surprised to hear my Tory colleague say that the service provider issue was one that he was willing to lose—

**Mr Jim Wilson:** At this time. This is the baby steps program.

**Mrs Sullivan:** —because it made a lot of sense during the hearings to hear from providers who had had difficulty and, in the case of the home care, who are working frequently in an isolated situation with no other individual working alongside them. Some of the abuse in that situation is a difficult one, and the bill of rights for the provider and for the patient or client I think has an equivalent value. Whether it's the right place or not, I guess the drafters will have a go at that, but I think the points that were made with respect to service providers were telling.

The other issue is in respect to the fairness of the employer to the people who work for them and who are providing service, and that's an issue that isn't covered anywhere in this bill. My own view is that the issue of the compliance with the bill of rights is better handled in clauses 41(c) and 43(d), so consequently I'll be voting against this and asking for support for later amendments.

**Mr O'Connor:** Just in hopes of clarifying what my suggestion was, which would be a friendly amendment, my understanding is that the bill of rights that we've got

in this bill is for the person, the consumer. That's why I was suggesting, after hearing, yes, the concerns of the providers but recognizing that the bill of rights is for the consumers, that it would probably be more appropriate that that section be friendly amended to reflect that yes, the bill of rights is for the consumer, the person who would be receiving the service, and then it would be more appropriate that this suggestion made by my colleague on compliance would reflect the person who's going to be doing the complying and then in turn is for the person receiving the service; that's all.

**The Vice-Chair:** Mr Wilson.

**Mrs Sullivan:** He's reading his news release.

**Mr Jim Wilson:** Ms Sullivan has just signed up to be an employee of CSIS, I think.

The logic here, if I may, is that it's all very nice that you can revoke the MSA designation if they're not complying with the bill of rights, but would it not make as much sense to ensure that a potential MSA has the ability to comply and give life to the bill of rights prior to giving them a full MSA designation? It seems to me up front you want to make sure that they're committed and that they have systems in place and the ability to comply with the bill of rights. Simply revoking things after the fact is one of the problems with many of our systems currently, so I think we should cover it at both ends.

Therefore, I don't understand the Liberals' reasoning on this and I hope the government will be able to come around to seeing that we've got to add as much teeth and enforcement capability and compliance capability as we can to the bill of rights or it's really nothing but a bunch of words on paper. That's the intent of this clause, and I think it actually meets the intent.

**The Vice-Chair:** Parliamentary assistant.

**Mr Wessinger:** Well, I just thought I'd say, Mr Wilson, you're being unusually persuasive on this matter.

**Mr Jim Wilson:** And?

**Mr Wessinger:** You might persuade me, yes.

**Mr Jim Wilson:** It's been suggested that I restate that I'm quite prepared at this point, as I said off the record—which might have made it on the record, I don't know; it's kind of a baby step approach here—to accept the friendly amendment by Mr O'Connor and in my amendment drop the reference to "and the service providers" at the end and add the word "and" after "section 3" in the amendment, if that's required by legal counsel.

**Mr Wessinger:** We would also delete "both."

**Mr Jim Wilson:** Oh, and delete the word "both." That would be a subsequent amendment. Would you like me to re-read it into the record?

**The Vice-Chair:** Do you wish to withdraw your motion and present the new motion as amended?

**Mr Jim Wilson:** Yes. I will withdraw the previous 7(1)(b).

I move that clause 7(1)(b) of the bill be struck out and the following substituted:

"(b) the agency is or will be operated in compliance with the bill of rights set out in section 3 and with

competence, honesty, integrity and concern for the health, safety and wellbeing of the persons receiving the service."

**The Vice-Chair:** Discussion on the motion that has been presented? All in favour—

**Mr Jim Wilson:** Another recorded vote, Mr Chair.

**The Vice-Chair:** All in favour of the PC motion?

#### Ayes

Carter, Malkowski, Martin, O'Connor, Rizzo, Wessinger, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Mr Jim Wilson:** You can't abstain.

**Mrs Sullivan:** I don't intend to, and you don't have to include that in the news release either.

#### Nays

Sullivan.

**The Vice-Chair:** Carried.

The next motion is a Liberal motion regarding section 7, Ms Sullivan, but it is first nation, so it will be stood down. We have agreed to stand down section 7.

In view of the hour, the committee meeting now stands adjourned until 2 this afternoon.

*The committee recessed from 1201 to 1412.*

**The Vice-Chair:** The social development committee is now in session, dealing with clause-by-clause of Bill 173.

**Mr Wessinger:** Mr Chair, I don't know whether we might be able to get the approval of the committee to hear a presentation from Mr Gilbert Sharpe with respect to the provisions related to the Substitute Decisions Act. It would not be the intention that we vote on that today, but I wonder if—

**Mrs Sullivan:** We're not close to that section yet.

**Mr Wessinger:** But it's going to be difficult to have Mr Sharpe available in the succeeding weeks because he is spending a great deal of time in Chicago. As he's here today I was wondering if it might be possible to get agreement to let him present an explanation of the sections.

**The Vice-Chair:** There is a request to the committee to change the order of business to hear Mr Sharpe at this time. Do we have consent?

**Mr Jim Wilson:** I'm surprised that the parliamentary assistant is bringing this up, given that we've spoken to Mr Sharpe and indicated that it would not be appropriate at this time. We certainly did indicate that we want to hear his presentation, but we felt next week would be more appropriate.

I would remind you, Mr Chairman, that the crucial part of the bill, the 80-20 rule, is to be debated momentarily. We have not got the time right now to skip to a new section which does not directly relate in any way to this piece of legislation, and therefore it would not be appropriate at this time. However, we are prepared to hear Mr Sharpe when he is available, either next week or the week after if these hearings proceed into that time.

**Mr O'Connor:** I appreciate the spirit of cooperation

in which my colleague speaks. It's just that Mr Sharpe has indicated that he's leaving for Chicago, where he is on a teaching assignment. He is available now, if we could have a brief moment. I appreciate that we are asking for cooperation that goes a little beyond what we would normally be requesting at this time, but the reality is that we do have his availability here right now.

**Mrs Sullivan:** We are now at section 11 of a bill that has more than 65 sections. The major and key parts of the bill, which will require extensive debate, have not been reached at this point, and the amendments which have been placed, to which Mr Sharpe has been invited by the parliamentary assistant to speak, don't relate to the bill. In fact, when they're placed they will be found to be out of order.

I think we should proceed in the normal way. If at a later time in committee the committee wishes to consider whether to request and receive unanimous consent for the introduction of what are clearly out-of-order amendments, that should be placed at a later time. My own view is that the committee will require more than Monday and Tuesday to complete clause-by-clause of this bill. Perhaps the travel arrangements can be accommodated the following Monday.

**The Vice-Chair:** Thank you. Mr Jackson?

**Mr Cameron Jackson (Burlington South):** The comments I wished to raise have been raised, so there's no need for me to comment.

**The Vice-Chair:** We will not proceed in that way.

Now we'll return to the bill. Section 8 is before you. Shall section 8 carry? Carried.

Shall section 9 carry? Carried.

Shall section 10 carry? Carried.

Section 11: We will deal with the PC motion regarding part VI of the bill first.

**Mr Wessinger:** I believe it's the one that deletes all of part VI and replaces it with a new part VI. Is that correct?

**The Vice-Chair:** Yes, that is correct.

**Mr Jim Wilson:** I move that part VI of the bill be struck out and the following substituted:

"Part VI

"Federated multiservice boards

"Establishment of boards

"11(1) The minister may establish federated multiservice boards and may specify the geographic area for which each board is established.

"Composition of boards

"(2) The federated multiservice boards shall be composed of,

"(a) the prescribed number of representatives of the approved agencies in the geographic area selected by the agencies in the prescribed manner;

"(b) the prescribed number of representatives of other service providers and consumers in the geographic area appointed by the minister.

"Same

"(3) In appointing representatives to a board under clause (2)(b), the minister shall take into consideration the board representatives selected under clause (a) in order to ensure that the composition of the board,

"(a) reflects the diversity of the population of the geographic area in terms of gender, age, disability, place of residence within the geographic area, culture, race, language and religion; and

"(b) includes persons experienced in the health services field and persons experienced in the social services field.

"Duties of boards

"12 A federated multiservice board shall,

"(a) ensure that persons within the geographic area for which the board is established have access to the community services available within or outside of the geographic area that are most appropriate to each person's assessed needs;

"(b) coordinate the provision of community services by service providers within the geographic area for which the board is established;

"(c) ensure that the community services available in a geographic area reflect the needs of the population in the area;

"(d) ensure the provision of information about the community services available within or outside of the geographic area for which the board is established; and

"(e) establish, maintain and operate a telephone service which will enable a person to access information on all community services available in or outside of the geographic area for which the board is established by dialling a single number.

"Board fees

"13 A service provider who provides community services in a geographic area for which a federated multiservice board is established shall pay a prescribed fee to the board."

#### 1420

This is one of the last opportunities I have on behalf of my caucus colleagues and I to put forward a federated multiservice board model, which would replace the government's MSA model.

The benefits of this approach, as I've described on previous occasions, are that it enhances the flexibility for local planning—in fact, this model would give maximum flexibility to local communities—that it broadens the scope for establishing new partnerships and efficient and effective coordinated systems according to local needs and desires, and that it builds on strengths of existing agencies rather than eliminating the VON, the Red Cross, Saint Elizabeth visiting nurses and many, many other organizations we've heard of, including commercial providers and other not-for-profit providers. This board would allow a partnership structure to be established. It serves the government's need to have coordinated access but does not limit the creativity of the local planning function.

Our version of part VI in this amendment requires no new administrative money. In fact, section 13 says the existing agencies, members of the federated multiservice

board, would be required to pay a fee for the administrative function of that board.

It does away with, I think, the most offensive parts of Bill 173, namely, the inflexible and overly prescriptive MSA model, as proposed by the NDP—we replace that model with the federated concept, which enhances flexibility—and it also does away with the 80-20 rule in part VI of the bill, the 80-20 rule which, as you know, has been the most often-mentioned problem we're dealing with in this bill. In fact, I would say that certainly over 95% of the presenters spoke against the government's arbitrary 80-20 rule.

To explain that to the listening public, this government, in putting all of those service agencies out of business, has decided that the multiservice agencies will not only coordinate long-term care services, community services, but also will deliver in a monopolistic fashion those services in each geographic area, therefore leaving only 20% of services for agencies that may exist, although I doubt they will continue to exist. But anyone left outside of the MSA that still might be in business gets 20% of the market share. It's the 80-20 rule, very clearly, that will put the VON, the Red Cross, Saint Elizabeth visiting nurses and countless commercial providers and not-for-profit community-based groups out of business.

We also believe that, by getting rid of the 80-20 rule, we stop the government in its attempt to do one-stop unionization under this bill, which clearly will be an effect. I will quote from the Christian Labour Association of Canada which actually had a very good brief—which I will find in a moment—that said very clearly that unionization would increase under this legislation, which seemed to agree somewhat with our theory.

If nothing else, the federated model and this section as proposed accomplish the goal of getting rid of the 80-20 rule, and I would like in a few minutes to discuss the 80-20 rule in further depth. It also gets rid of the four-year transition period contained in the government's bill, another area of concern for providers. It should and will address the problem we have in discouraging volunteers under the government's proposed MSA model, because we suggest we do not abandon those service providers that have been providing services in our communities for the last century.

I welcome comments. I know the government, in previous amendments, and the Liberal Party, have rejected the federated model. However, I would ask you to reconsider at this time. This amendment, while not perfect, does attempt to address the major problems with the bill in a significant way. If accepted, I think you'd find that these hearings would go a little quicker, that the ad hoc coalition that has formed to oppose this legislation would be very, very happy indeed, and that many of the problems you are encountering in getting this bill to this stage—and indeed you will encounter even more problems getting this bill through Parliament—will be very much diminished if you will either accept this amendment or subsequent amendments to get rid of the 80-20 rule.

Mr Chairman, I will have more to say in a few minutes.

**Mr O'Connor:** I appreciate the opportunity to speak

on Mr Wilson's motion. I think it clearly points out where they're coming from on this model as they see it.

The point that seems to be missed here is that you can't have, for example, any administrative streamlining in this process. How can you, when you keep intact all the different agencies—for example, here in Metropolitan Toronto, 150 agencies—and expect to see some efficiencies within that?

Consumer membership on the board: How do you guarantee that? He's suggested he wants to include that in his motion, but let's be real here. There are 150 here in Metro, and then to try to put the consumer representation that's required in there with all those agencies, it is going to be an extremely difficult process to try to put in the consumer membership that's necessary on the board.

The main focus of the legislation is lost in this PC motion before us. The fact is that all the seniors' groups we heard from didn't want a federated model. They didn't see this as the model they envisioned. They didn't see an amalgamation that brings all the existing agencies together to the table to do it, and to continue with all the functions they provide today in a fashion that isn't going to be responsive to the needs of the consumers.

The problem is that not every part of the province has the full spectrum of services and they can't be found in every section. What we're trying to do is reform a system that's going to recognize the deficiencies and expand those services in other parts and put in local accountability, involve the consumers in the boards right from the beginning. The MSAs aren't just expected to coordinate the services, they're expected to pull together all the needs of the community, bringing the maximum amount possible of consumers: One third is the suggestion we've talked about many times in this committee, and I would suggest we could probably go further than that; if we want to respect the real needs of the consumers, I think we could even go beyond that.

That's not part of this amendment before us, but frankly, I don't think he's adequately addressed the needs of the consumer. I don't think, for all the duties he envisions in this federated multiservice board, that it is going to recognize the reform that has been part of this discussion for all these years. The reform was never based on a status quo system of continuing everything that exists and then it's just build one more layer on top of it all: "Let's have a superlayer now. We've got all these different 150 agencies, for example, in Metro here out there today. Let's keep all of those 150 out there, and on top of that we'll put the superfederation model up on top of it."

I use the analogy, maybe somewhat tongue-in-cheek, of renting out the Legislative Assembly so they can have a board meeting. It's really hard to picture. It's really hard to picture 150 agencies coming together and then pulling together the very necessary consumer element. That's what people were asking for through this process.

It just doesn't seem to work as far as I'm concerned and I certainly wouldn't suggest to any of my colleagues that they support this motion. I guess we'll probably have a considerable amount of discussion on it this afternoon. I welcome the opportunity to hear how they think that

just developing a 1-800 status quo phone number is going to solve all the problems, because I don't think that's going to solve the problems. It just doesn't work that way. But I'm certainly willing to listen to the conversation and dialogue as we continue.

1430

**Mr Wessenger:** Mr O'Connor made a lot of the comments I was going to make, so I'll probably be quite short. I think it's kind of interesting, the model that's proposed. I know the member for Simcoe West likes to take himself away from his historic past in connection with Bill Davis's Conservatives, but this is something that they might have come up with, establishing another level of bureaucracy which will only add to the cost of the system and make it more cumbersome. It's interesting to see there is some going back to the past, there are some aspects of the traditional party background.

When you create a new bureaucracy, you have to decide, "Is it replacing some existing bureaucracy?" No, it isn't; it's just an add-on. We have an add-on situation here, and if you look at what this add-on bureaucracy's going to do, the only thing I can find in section 12 that it says it's going to directly be responsible for is, first, it's going to coordinate service providers, whatever that means, and second, it's going to maintain a telephone service. This seems an awful lot of energy wasted to do only a coordination role and a telephone service role. It's not even going to do the assessment role directly, which was going to be done in some earlier model. It really, I think, is a very ineffective model.

Secondly, of course, the major objection is the fact that, in principle, it's completely opposed to what we are seeing as to what the governance model should be. Our governance model is to be responsive to the community, to have consumer representation. This board is obviously just going to be controlled by the agencies themselves, so it's really just the vehicle for the service providers and not really the vehicle for the community.

On those grounds alone, it's not a good model at all, it's not one we should consider and therefore I can't see any way how this could be supported at all.

**Mrs Elinor Caplan (Oriole):** The concern I have about the motion that is before us is that it is a one-size-fits-all template for the whole province. Our view, and my personal view, has been that because Ontario is so diverse, what's going to work in one community may be different than in another. And, as you know, I have grave concerns about the proposals of the government because I also see it as a one-size-fits-all template coming from Queen's Park.

I believe that what is the most effective way is allowing the flexibility within the development of a long-term care system that would see perhaps a federated model in one place, an MSA that does full-service delivery someplace else, a coordinating, single-access organization which does purchase-of-service contracts in another location, because by the very nature of Ontario the differences might require those kinds of different solutions.

What I think is significant in the legislation is that there are a couple of components which I think work

against the achievement of its very same goals. I think the motion that we have before us attempts to deal with a couple of those, particularly on the 80-20 rule, which frankly I believe is going to result in less service for people. The goal of long-term care must be to see that people get the care and service that they need, when and where they need it in a coordinated system of access to long-term care services.

While the motion placed by my colleagues from the Conservative Party would attempt to address that part of it, it does so in a way which I think lays on a one-size-fits-all solution across the province that, frankly, I don't think will work any better than what the government has proposed, because we need to have flexibility to respond to the different needs of different regions in the province.

I want to say clearly that I think the 80-20 rule should come out of the government's legislation. I think that it is perverse to the intent and the goal of the legislation, which is that people have access to the services in their community.

Second, I believe very strongly that the MSAs prescriptively should not be the deliverers of all services. I think that will result in higher cost and less services, again, for the people in the communities across this province and I think that model does not achieve the principles upon which long-term care is predicated.

However, as I speak primarily to the Conservative motion that is before us, it does not fix the problems that the government's legislation presents to us. While I support the intent and the principles of long-term care and I believe that we need to develop a long-term care system, because what we have today is a non-system, I don't believe the Conservative motion that is put before us will accomplish that in a way which is responsive to the needs of people in our communities. Frankly, I don't think that, as an amendment to the government legislation, it would fix the flawed components of the government's legislation to implement long-term care reform.

So I can't support the Conservative motion, and I would ask the government to reconsider imposing a single model that is inflexible, that might well and probably will, if implemented, mean more cost and less service.

As to the four-year implementation transition period which the PC motion removes, I think that should not have a time limit on it. It would be a very positive thing to allow a much longer transition time, and I don't think there should be a time on it. I know that our party has proposed that the four-year restriction be removed as a significant amendment to the bill. But again, while there are a number of things that I think could be done to fix the government's legislation, what I'm not seeing is a basic understanding of the inflexibility that has been created. Unfortunately, the PC motion that is before us now does not bring that flexibility and in fact puts in place another inflexible model.

**Ms Carter:** I'm glad that the Tories do at least have a plan. That's something, in contrast to the Liberals, but my criticism of this amendment is that it would simply destroy the whole point of Bill 173. We might just as well pack it in and not bother.

As you know, we did consult grass-roots seniors and potential consumers and they do not want a bureaucracy. What we're looking at here is a wonderful bureaucracy, layers of it, like regional government, where you have groups on top of groups, and all the things that we're trying to achieve—the cost savings, the better governance, the better service for the consumer—would just disappear. Worse still, we would have a conflict of interest because the board would consist of providers who would be using government money. They would be deciding how to dispense it to their own members. I find this totally unacceptable and unworkable.

#### 1440

The whole point that we have taken care of in our legislation, that consumers should be represented, will be lost. The only consumers would be ministerial appointments. I think even if it hasn't been clear to people all along that the MSA boards would in fact be elected locally, this is the case. This is going to be something not laid down by the government but which is based on local democracy.

We've heard from the Liberal side that what we're suggesting in Bill 173 would not allow for regional differences, that it's somehow imposing a pattern, and I certainly dispute that. I think what we're doing is allowing for a great deal of local difference. We're laying down a minimum as to what has to be provided, but subject to that minimum, we're saying that this is not a cookie-cutter approach.

As I said, it will be based on a different evolution in each locality as to how those agencies come together. Obviously agencies covering all the different services that need to be provided do not exist in every area, so if we just allowed those agencies to come together, we would still have a system where some regions were much better served than others. What we're looking at here is having agencies merge but also making sure that we can supply the deficiencies that do exist in some areas.

I would suggest that the Liberals, although they are criticizing what we're suggesting, do not have a plan, which is no change, no different from their normal situation on most issues.

We are told that the 80-20 rule is counterproductive. I would dispute that. I think we have that rule in place because we want the MSAs to integrate services to provide them themselves. In that way there can be much more flexibility, much more adaptation to the needs of different consumers, whereas if you have loosely federated agencies, those agencies have fairly rigid boundaries as to what they provide on what basis, and that is what we are trying to get away from. We're trying to say that each consumer will be assessed once only, will be looked at and will be given a plan of care that is unique to that person.

I don't see any advantage in having competing agencies all providing the same service. In any case, the consumer has never had the choice as between, say, Red Cross, VON or Saint Elizabeth, because they haven't all existed in each area, and if they have, it's been Red Cross if you apply on Monday and VON if you apply on Tuesday. There never has been that choice.

What we're putting forward in Bill 173 provides a whole series of advantages. As I said, it provides cost savings, because we're doing away with excessive administration which the Conservative proposal would put back in spades, it provides locally based, democratic, consumer-driven governance and it provides better and more flexible service. So I suggest that we turn down this amendment very forcefully.

**Mr Jim Wilson:** It's been a very interesting discussion about somebody else's motion but clearly not the one on the table. The one on the table has maximum flexibility. Perhaps I should explain it as I did the other day in case people aren't reading it correctly.

I have no idea how you get the idea of a new layer of bureaucracy. In fact, your own MSA model is a new layer of bureaucracy, because you destroy anything out there now and create a new bureaucracy.

What this says is, this gives the existing service providers in a geographic area—"in a geographic area" is important and it's in your own bill, which I'll get back to in a minute, Mr O'Connor, because you commented on having too large a federated multiservice board. This sees the reality out there that there are existing service providers in each area of the province. It says to those service providers in a legislative way, "You get together in a federated model"—that is, and I'll stick with my local area, which I know best, which has seven players ranging from the ones that are most often quoted—VON, Red Cross—down to about 3% of the services which are delivered by the private sector, and that I think is Para-Med.

So you have about seven players delivering services in Simcoe county. There's a geographic area. This bill says, "Each of you seven players in 11(2)(a) send a representative or the number prescribed in the regulations," and we had to do it that way to give the greatest amount of flexibility to local areas. In fact, our vision is: "You tell us how many reps you need for the multiservice board and you each appoint someone to this board. If that ends up having seven people on it in Simcoe county, great. Those are your seven appointees." So that fulfils (2)(a) in terms of getting the service representatives, including the private sector representatives, on that board.

Then (2)(b) says the minister will appoint consumers to that board. Later on in the regulations we would get into the mix you want there, but we couldn't be overly prescriptive at this point because, while there are seven major players in Simcoe county, there may be more or less in Metro and in the north, for example. But our vision is that each of the existing agencies appoint someone to this board, which meets the objective of beginning to coordinate these agencies rather than tearing them down and starting all from scratch. We will then make sure there are enough consumers to have meaningful input at the local level.

We eliminate, for example, the mandatory services at this point because we want those people to tell us the following thing: "As a federated board, you are then charged under this legislation to tell us what the mix of services should be and the appropriate services for your area, based on previous amendments that called for

needs-based planning in that area."

So it's not a new level of bureaucracy. It's taking the players that are there now, forcing them together, if you like, in a partnership board and saying, "You get back to us about the provider mix of services for your area and all of the other things required as the purposes of this act."

I want to just quote from the Canadian Federation of Independent Business, which, in its presentation to this committee on October 11 this year, I think in a couple of sentences summarized exactly what the purposes of this bill are, and it's time we reminded ourselves of this:

"The stated purposes of Bill 173 include: ensuring that a wide range of community health and related services are available to people in their own homes so that alternatives to institutional care exist; improving the quality of these services; promoting the efficient management of their delivery; and ensuring local community involvement."

Community involvement is there with (2)(b). The absolute requirement that new bureaucracy not be set up is there in (2)(a), which says take existing players, put them together and have them beginning to work cooperatively which, as I said the other day, is happening already in many areas of the province. Let them determine the levels and needs and types of service that are going to be provided because we are working within your own envelope-funding scheme. They will be told that there are only so many dollars and that they must provide community services in their community based on geography.

We also eliminate, I should say as an aside here, through our amendment the mention in the government's bill of the bias against the boards of health and municipalities too. The government is using them as last-resort MSAs and effectively making sure that boards of health and municipalities could not ever become MSAs, as currently constructed.

Mr O'Connor talked about the 150 agencies in Toronto. If they each appointed one member to a board, there'd be 150 people on the board and therefore you'd have to put so many consumers on that board that the board would become unwieldy. He forgets that the rest of his own bill, which we don't change, talks about geographical areas designated by the minister, so you wouldn't necessarily have 150 from all across Metro on one board. You would have smaller boards to which you can appoint consumers.

#### 1450

There are ways, because it is done as prescribed in the regulations. We may have to say that if it was a small geographical area like Etobicoke, if it had 150 players there right now—which I gather you're trying to tell me, which I don't believe—its federated board would have to be prescribed a little differently than in the regulations. But this clearly says: "You have the freedom now, existing agencies. Appoint someone to this board. We'll appoint consumers and other providers and players, and you get back to us about the services."

It is the furthest thing in the world from a template or a one-size-fits-all model. The government's MSA model

is very much an overly prescriptive, cookie-cutter approach that the minister specifically said would not happen; it has happened. Whether by default or intention, it has happened. You go into such detail of what must be done by these MSAs and what they must look like in each area of the province and you leave no choice, because you wipe out all the providers that are currently providing choice in the system and you create a monopoly of delivery of services.

This federated multiservice board would not deliver the services. It simply, with no new administrative dollars, is asking the current players to get together, and consumers, to coordinate the services, do the common assessment tool and provide the phone number or the one-stop access point.

We're not giving you any more money for it. You're going to have to find money in your local Red Cross budget and your VON budget, and the private providers will have to pitch in too, to provide this one-stop shopping office.

In Simcoe county I can see it fitting into one of the actual physical offices already there of the current players. Red Cross has got room in its office in Barrie, for example, to provide room for the federated board.

The board may only have to meet, initially, once a week or so to begin coordinating services. Once services are coordinated, it may only have to meet once a month, as so many other boards in this province do that are made up of federations. It's definitely got maximum flexibility for the people of that area. You couldn't think of a model that's more flexible, I don't think. It is not another layer of bureaucracy, as the NDP's Mr Wessinger has accused us of; it's the furthest thing from that.

It provides coordinated access. As I said, it gets rid of the four-year restriction. There's no need for a four-year restriction because the federated board is not delivering services. It is coordinating services; the existing member agencies will continue to deliver the services. Because frankly, government, with all of this legislation and without this legislation, you hold the final say in this matter anyway, with your funding lever. You're able to meet your objectives of this coordinated access through current funding arrangements, if you really want to, and probably don't even need this legislation. But what we're saying is, if you're going ahead with the legislation, go with a federated board.

I want to talk about the 80-20 rule, and I know a lot of people do, and about the government's inherent problems in its own legislation. I thought one of the best briefs was from the third-largest union in long-term care and community services, the Christian Labour Association of Canada, presented to this committee on September 13.

I want to begin reading from a section entitled "Unnecessary Rigidity of MSAs." They're referring, of course, to the government's bill, the government's MSA model. It says:

"At the heart of this bill rests the premise that new government agencies will be able to ensure more efficient and better quality care. This is a premise we would challenge and would like to discuss with the committee.

In the creation of multiservice agencies, we observed the introduction of various rules and rigidities that are likely to be counterproductive."

This is the third-largest union in the system now. "Let us be clear: As we stated earlier, we fully support the objective of long-term care...." They go on to list the objectives, and they are exactly the same as the ones listed by CFIB. But it goes on to say that Bill 173 does more than just meet these objectives.

"It provides not only a single access point for the public, but the MSA will be the only way to access long-term care services. No matter how much stock we put in the community representative boards and how much we legislate respect for linguistic, cultural or religious diversity, the MSAs will govern and direct where individuals will receive care. Agencies and institutions that were established to serve the needs of a particular linguistic or cultural community...or that provide care on the basis of a certain philosophy, will inevitably change or disappear. There is no incentive or structure that will accommodate their continued existence and growth, and that is a loss for our health care system. No single agency, regardless of how community reflective or well intentioned it is, will be able to provide the diversity of service which is part of the richness of our current system."

They question in the next section, Mr Chairman, if you'll bear with me, "Why the Requirement that MSAs Deliver Service?" so specifically to the 80-20 rule. This is a union speaking.

"The elimination of the diverse services will occur because of the requirement that the MSA not only ensure access but also deliver"—and they italicize "deliver"—"at least 80% of the service. This reduces consumer choice. It also places the MSA in an inherent conflict-of-interest position." Both points that Mrs Carter said would not occur this union says are occurring under the government's model. "The MSA will have control over funds, be responsible for ensuring that regulations are upheld and manage the delivery of service. At the end of the day, all of these functions will report to a single board of decision-makers, who inevitably will have to rely on the professionals who will run the MSA on a day-to-day basis.

"By virtue of the provisions of this bill, MSAs are being placed in virtual monopoly positions, responsible for the total delivery of long-term care services. Whenever a monopoly position is afforded, questions of accountability are crucial. The bill before us deals with accountability by instituting an appeal process," and it goes on to discredit the appeal process. At the end it finally says in this section that the monopoly position is not the way to go.

It calls on, ironically enough, in the next section, entitled "Government Bureaucracy More Efficient?":

"When our members ask us why the government is proposing to eliminate the various agencies that currently serve the community and replace them with a government agency, we've provided the government's stated rationale: This is supposed to eliminate the duplication of management and overhead costs and increase coordination by placing them within a single agency. The response

usually runs something like this," quoting from a quote in their brief, "'You mean the government actually thinks that one of its agencies is going to reduce overhead costs by creating a new bureaucracy? By the time they have their directors, communications persons, newsletters and consultants paid for, I doubt a penny will be saved.'"

The brief goes on to say, "Call it cynicism if you like, but the reality is that government agencies do not have an inspiring track record in their ability to stretch scarce resources and manage efficiently."

The next section is "Bias Towards Not-For-Profit: A Red Herring."

"One factor that enters into the government's rationale is its stated preference for the not-for-profit segment of the health industry. As a union, CLAC deals with community-based, charitable, municipal and commercial agencies. In our task of representing employees, the corporate structure represented on the employer side of the table makes little difference in the quality of care provided. There are those who argue it's inappropriate for health care dollars to end up as corporate profits. While we have sympathy for the argument that public dollars need to be spent efficiently, with value for money, our observation is that as much money is spent profiting management types in some of the so-called not-for-profit sector as it is in the commercial sector.

"When, for example, a Revenue Canada taxation form indicates that a single executive officer of a home for the aged received remuneration of \$136,000 in 1991, more than double the average for that position in the private sector...we have little sympathy for the position that the not-for-profit sector is always to be preferred to the commercial sector.

"We need to be aggressive in ensuring that public funds are not benefiting certain individuals, whether they head up a private corporation or a public board. In our work on the long-term care funding committee, CLAC," which is the Christian Labour Association of Canada, "has worked hard for and supported measures that addressed these concerns. But the proposition that we need to target the elimination of commercial agencies in order to save the profits for our health care system is a red herring argument. In many instances, for-profit institutions deliver as good if not better care in this sector, for substantially fewer dollars than the better-funded, not-for-profit institutions."

1500

They go on to talk about that worker choice is lessened under the government's MSA model, and at the end they say:

"In summary, the requirement that multiservice agencies deliver, rather than just provide access to, services has consequences that are detrimental to the delivery of quality long-term care services. This requirement will have the effect of minimizing consumer choice and reducing the diversity of services available to Ontarians, creating a government bureaucracy that is unlikely to improve the efficiency of the system, giving rise to employment circumstances where all workers will become employees of larger agencies with the result that

individual employees will be less able to make choices and meaningfully influence their work environment"—we hear that complaint often in our own large government ministries where, when you're that big, it's very difficult for individual workers to have any meaningful say in their work environment—"and causing a conflict of interest within the MSA board which will have to fund, regulate and manage the delivery of services. While mechanisms of appeal are established for those who are denied services, consumers and employees will have less recourse in dealing with quality of service concerns."

They go on to plead with the government to eliminate the 80-20 rule, and I could go on but I know those are the important parts of their brief. Interestingly enough, if I could have found it, I know there was a line a little earlier on that talked about, "Inevitably this bill will lead to increased unionization in the province and therefore increased cost to the system."

I also want to quote from Ms Delores Lawrence, who's president of the African Canadian Entrepreneurs. She says:

"Section 13 of Bill 173 limits the amount of service an MSA can purchase from any agency, private sector or otherwise: no more than 20% of all the home care services being provided by the MSA." That's the limit. "The government had planned to limit...the sector to 10%.... However, when the legislation was introduced, the government extended the ceiling to include all providers who are not part of the MSA," and the ceiling went to 20%, she goes on to say.

She then points out a fact: "Private sector companies face a crisis situation. More than half the commercial home care agencies in Ontario account for almost 50% of the services provided in Ontario." Your bill will wipe out half of the services of the people currently delivering services in this province. They are in the commercial sector and you'll be putting them out of business.

She says of the future: "There is no doubt that if the commercial agencies go out of business, the employees will also be unemployed. This is not encouraging news. Many home care workers are minorities and women." Many are single parents. "How can these laid-off workers be guaranteed jobs when the government made commitments during the social contract negotiations to fill new jobs in the health care system with unionized hospital workers who were laid off? This means squeezing out this disadvantaged group."

She concludes that not only will she and her colleagues be out of business, but there will be a tremendous displacement of workers. I know the government has an amendment to try and deal with that displacement, but we're certainly not satisfied that even that amendment that's coming up will in any way provide a great deal of comfort to those people who are currently providing just about half of the services in the province and are employed by the private sector.

I reject the criticism that's been made by the other two parties. I think if they would please re-read the amendment and honestly admit that it doesn't create a new level of bureaucracy; that it is a partnership model; that it absolutely provides the most maximum flexibility; it is

not a template, cookie-cutter approach; it provides for consumers in an extremely meaningful way, and therefore I would ask that people support this.

It eliminates the major problem, that is, the 80-20 rule; it eliminates the transition period the government has put in place; it ensures that the current providers will continue to provide services to the province, so you're not reinventing the wheel or creating a new bureaucracy, and it very much creates a partnership model. I think, in that sense, it survives all of the tests and supports all of the stated objectives, the truly, publicly stated objectives of this phase of long-term care reform, and I would ask that members support it.

**Mr Tony Martin (Sault Ste Marie):** I want to say at the start that this piece of legislation is a perfect example of the approach that we as government take to a lot of these very difficult restructuring questions. We take the bull by the horns and we make it happen in a way that brings a high degree of accountability and responsibility to the question of how we spend money and redirect it to the place where it's needed the most, which is out there delivering service.

I'm both happy and surprised that the Conservatives would bring this particular amendment forward because it certainly gives me an opportunity to indicate the difference there is between how we approach government and the kinds of things we've been doing over the last four years to try and restructure government, redirect resources so they in fact do help people, and how it has been done historically in the past both by the Progressive Conservatives and by the Liberals when they had their turn, short though it may have been.

**Mrs Sullivan:** Not as short as yours.

**Mr Martin:** And that Mr Wilson here would in fact be the one bringing this forward as well—I heard him, as we travelled the province on a number of occasions, liken this piece of legislation that we're bringing forward to the regional government exercise that was brought in by his predecessors, which was an attempt to bring smaller governments in under one umbrella at a time when there was, as there now is not, a whole lot of money around.

There was a plan put in place to bring in regional government and then, over a period of time, phase out the smaller municipal governments that we still see out there. But they, in the end, didn't have the backbone to do the job completely, which is to make the regional government the only government that was present in a particular area.

So you had two levels of government which is what he's proposing in fact, in some significant way, here in this amendment, that we make change, but really not make change; that we, in name, put together a new board and a new delivery agent, but in fact continue to use the same structure and delivery system that we've always had. I guess it's important that I say this piece of legislation is in no way a judgement of the very valuable work these organizations have done over the years.

It is in fact an attempt by this government to improve the level of service and improve access to service. This is where I want to get now to the Liberal approach to

this, or the message that I'm hearing reflected in the member from that party's comments to this particular motion, that we should allow for geographic areas to have the flexibility to do what they feel is in the best interests of the people who live within their geographic area. In fact, that was the way long-term care has evolved over the last five to 10 years in this province where some areas had Cadillac versions and other areas had Volkswagen versions.

**Mrs Sullivan:** It's not right.

**Mr Martin:** Sure, it is right. It is right and that's the reason this piece of legislation has come down, because some areas have a wealth of services while other areas have no services. As a matter of fact, there was a comment made by personnel from—

**Mr Jackson:** Everyone should drive a Volkswagen. That's your point.

**Mr Martin:** Well, I drive one, so what the heck.

**Mr Jackson:** I thought you had a Lada.

*Interjections.*

**The Vice-Chair:** Order. Mr Martin has the floor. Please continue, Mr Martin.

1510

**Mr Martin:** Counsel for the government this morning talked about how funds were, even now as we speak, being distributed across the province to reflect the fact that in this province right now there are areas getting an adequate amount of money to deliver the service, while other areas are not. Through this legislation and through the new resources we're putting into the envelope, we're going to make sure that a couple of things happen.

This legislation is about a balance between making sure there is consistency in standard of service across the province. It's about making sure there's equal access from one corner of the province to the other. It's about making sure the same basket of services is available to people in places like Wawa as is available to the people in downtown Toronto. That's what this legislation is about. At the same time, through the MSA, through elected boards at the local level, it will allow people at the local level, which is happening as we speak, to decide what the MSA will look like, to allow the flexibility that will be required to make sure each area gets what it deserves. That's what this legislation is about and that's why it's crafted the way it is.

I guess I'm surprised and not surprised, first of all, that the Conservatives would bring this forward. It's change without making change. It's speaking out of both sides of your mouth. I'm not surprised that the Liberals argue for the status quo, for not moving ahead. For a very good example of the kind of change Liberal governments over the years have attempted to make in this country, just watch the package that will unfold at the federal level over the next year or two as they try to come to terms with the reality we've been dealing with—

**Mr Jackson:** Sort of like the social contract for poor people, right?

**The Vice-Chair:** Mr Martin has the floor.

**Mr Martin:** —as they try to come to terms with the

very stark reality we have grappled with very successfully, I might say, yes, through the social contract and, yes, through our expenditure control plan and, yes, through pieces of legislation such as the one we have in front of us, which helps us grab hold of service delivery models that have been developed patchwork-style over the last few years and do not reflect the reality of today, do not deliver in a way that I think the future is going to call governments to deliver.

I appreciate being able to put these comments on the record and will be voting with my colleagues on this side of the table to stay the course, because it is the right course at this particular point in time. It is restructuring in a way that is real and in a way that reflects our great interest in making sure that the dollars spent are in fact spent to serve people, as opposed to continuing to support a whole raft of administrative structures across the province.

**Mr Gary Malkowski (York East):** I've been reading the Progressive Conservative press release and I have a problem with some of its contents. This is your press release and I'm commenting about this. This was released today, and what you say here in the committee is often in contrast, so I'd like to raise some of these points.

You say in this press release, pulling lines from this, that you're going to "be sensitive to and respond to" their ethnic, spiritual, linguistic "and cultural needs." You say that, but in the last paragraph you talk about how you're going to focus on supportive sensitivity and the rights of service providers.

There's no reference at all to follow the concerns of consumers and there's not one word or one mention of the Ontario senior citizens' alliance in here. You only talk about Saint Elizabeth visiting nurses and the Red Cross and that kind of professional organization. There's not one word about consumers as related to the Ontario senior citizens' alliance. So what you say and what I see here in the press release—I have a copy of it; there it is—are in contrast.

**Mr Jim Wilson:** Do me a favour. Read the whole thing into the record.

**Mr Malkowski:** Another fact I'd like to point out is that Mike Harris is going to be speaking to the Ontario Association of Professional Social Workers later today, and in the quote, just three lines in here, he talks about how he's going to remove "170,000 disabled or unemployable Ontarians from the welfare rolls," with "mandatory 'workfare' and 'learnfare' for able-bodied recipients."

**Mr Jackson:** That's right, because it's degrading to be on welfare. How would you feel, being disabled?

**Mr Malkowski:** It also goes on to say, with regard to new programs for literacy and for parenting, child care, that you will not cover some of that. I want to know, where are the programs for senior citizens? You don't mention anything about that in here.

It's hypocritical, to a certain extent, to say one thing about how you're going to be sensitive to the needs of people in Ontario and at the same time have press releases that say the opposite. I want to tell the public

who are listening: Don't be fooled by rhetoric. Don't be fooled by this so-called Common Sense Revolution. I would challenge all of you to read what's being put out, and here are the press releases right here.

Where's your commitment to long-term care? Do you confirm that what I have right here is true? We have it right here on the record. I have it right here; here it is. Where is your commitment to preserving and recognizing the rights of senior citizens and consumers, disabled and senior citizens? Where are their concerns? Where are the concerns raised by the senior citizens' alliance in your press releases? They're not here anywhere. You've completely ignored them. You've forgotten all about them. You're not listening to the senior citizens of this province, specifically the senior citizens' alliance, who represent, I might add, over a million people.

Why can't you listen over there? I don't understand. The Ontario senior citizens' alliance is important. We are attempting in our legislation to listen and to be sensitive.

**Mr Jim Wilson:** On a point of order: You voted against two amendments we put forward on behalf of the coalition, the senior citizens' alliance.

**The Vice-Chair:** It's not a point of order. Is Mr Malkowski finished? Thank you.

**Mr Sullivan:** I think this is an interesting amendment the Conservative Party has put forward. We will not be supporting it, and there are substantial reasons we will not be supporting it.

To explain our rationale, it's important to understand that in the course of the development of long-term care reform policies, our party has always been committed, first of all, to a single access, a coordination of services, and a service approach that will provide a seamless continuum of services. The emphasis on quality of care, on evaluation of services that are provided, is also very much a part of our concern.

We also believe there should be a mandatory basket of services, and we are supportive of the government's bill in that it does say that everywhere in Ontario, in every community, the long-term care services that are available will be equivalent and there will be equity in access. We believe that for too long, people in certain communities, simply because of their geography or because of the resources, whether financial or human, have not had access to those services which are considered a matter of course in certain other areas of the province. So we're pleased the government has indicated that there will be a mandatory basket of services as part of a long-term care program.

1520

We also are pleased and have insisted that the central government, ie, the province, should be responsible for setting the policies, for defining the goals, for determining the rules and the regulations around which long-term care should work so that every single part of long-term care reform is based upon standards that are comparable in eastern Ontario, in northern Ontario, in southern Ontario, in central Ontario and in the small communities, whether they're rural or mining areas or forestry areas or whether it's a downtown urban environment.

The consistency of the rules, the consistency of the services, the consistency of quality, the assurance that there is evaluation of the services is fundamental to our approach to long-term care.

Similarly, we also believe and we have recognized over a period of many, many years that one of the enormous problems in long-term care is the way people access that care. Too frequently, it's uncoordinated; people have to go to 18 different sources. There is no single place where a person can even receive information, let alone seek to find appropriate assessment and subsequent services.

I think it's important that the government members, who continue to distort our view of long-term care, and the third party understand that those are fundamental parts of our approach to long-term care reform.

Having said those things, we also believe that individual parts of this province have different priorities, have different methods of working within and achieving those goals we have set out, and it is paramount and of vital importance that local communities, using their local human resources and gathering together their local wits and experience and expertise, should be able to design the structure in which those principles and priorities would fall.

In some communities, the government model may well work and be the most effective and efficient model available for anyone. In other communities, that will not be the case. Other communities may well choose to look to their boards of health or their public health units to take responsibility for the delivery of long-term care. In other communities, a service coordination model may well be most appropriate, depending on the geography and the nature of the demographics of that community. In other communities, a federated model, such as has been put forward by the third party, may well be the appropriate model. It is, however, incumbent that for this system to work, the local communities, based on their own geography, on their own resources, on their own history, on their own expertise, should determine the structure.

We know and we accept and we listen, and we have indicated our support for envelope funding for long-term care. We have not raised objections to that, other than that we have indicated earlier today that we want to have the assurance that all of the medically necessary services included in our medicare plan continue to be included and recognized in long-term care. We are deeply concerned that this new funding envelope may well jeopardize what are now insured services.

None the less, within those principles, we believe there needs to be a structure and a surround for long-term care that takes into account the views of people in the community about what is best for them.

I have mentioned before the instance of Renfrew county, where one institution, which is more than an institution, because it happens to include a long-term care facility, adult day programs, home care etc, basically now serves as what is an effective MSA and provides service for that entire community. That community may say they don't want to change that, that it's worked in history, it's one of the best-coordinated in the entire province, so why

should they change? Why should a new bureaucratic structure have to be set up to bring in what has in effect been done extraordinarily well, with exemplary quality standards and enormous care? There's no need for change, perhaps, if that community says there's no need for change.

In Kitchener-Waterloo we know the communities are working very well already, and have for several years, in an integrated way, with cross-consultation in a multi-disciplinary approach, and the government single model is going to destroy all that cooperation and coordination that has existed, has built up over a period of time.

In other areas, as I've indicated, we believe the government model may well be the most appropriate model. I do not believe, from what I've heard and seen in northern Ontario, that the government model will work in most communities because of the particular geography and nature of services that are required, particularly in northwest Ontario and in far northeast Ontario. It seems to me to be highly problematic to introduce a new, highly structured, inflexible template when the emphasis should be on what should be delivered and on the standards around which that service and that care should be brought to the people.

The Grey-Bruce branch of the VON wrote to the Premier on October 18, and I'd like to quote from that letter.

"We do not believe that Bill 173 will meet the needs of the communities unless there are amendments to it to allow for models for the MSA to be developed locally. We believe that the multiservice agency system must be flexible and built from local community needs, experience and strengths while meeting the principles of the long-term care reform and provincial goals. For the purposes of Bill 173 to be achieved, our board believes that service delivery models and governance structure for the multiservice agency must be developed by the local community."

For over two years people in communities have been working on long-term care committees throughout Ontario, trying to come up with solutions to what is the most effective way to bring to the people a coordinated, multi-disciplinary, quality approach to long-term care, which everybody in this room recognizes has had serious problems in the past. Very few of those communities have put forward the government model as the ideal approach to coming to terms with what their needs in their local communities are.

For two years people have been labouring, have been attempting to bring special interests and unique interests together. They've had consumer participation, they've had patient participation, they've had professional participation and health service provider participation, and they've been brought together around the table. They've had public stakeholder meetings and have spent enormous amounts of time, energy and skill on this entire issue of what shape their delivery system should take in order to serve their community within the provincial standards and goals and criteria.

Last June, when this bill was introduced, for the first time they heard that the government was limiting itself to

one inflexible model where there had to be one agency, a multiservice agency, in which the access and the service delivery were provided by the same organization. That had not been contemplated. The discussions in the past, the instructions and the information that went out to the district health councils, to their long-term care committees, through materials that left the minister's office and the long-term care branch, never contemplated that.

Thousands and thousands of people across Ontario, of goodwill, of strong mind, of deep commitment, have been working for over two years to try to come to terms with how we are going to have a better long-term care system where standards are high, where the difficulties and problems of the past are, to the best of human ability, eliminated and where changes bring improvement for the people who are affected by this system.

1530

We can hear all the rhetoric about how parties on this side of the House don't care about the consumer. The consumer is our fundamental interest here. We believe in a patient/client-focused approach to long-term care reform, and that's why the principles and goals that are set out by the province are so fundamental to our approach.

None the less, if you are going to ensure that people do feel in every community that they have a stake in this issue, then you'd better give them a right and an opportunity to participate in the planning and the development and the approach of their own system.

We will not be supporting this particular amendment, because we believe that it is, in its own way, as inflexible and as limiting as the government's model. We believe that local communities must be involved in the decision-making. If you don't allow that—and I'm urging the government to change its own single-model approach, and we will have a number of opportunities in other amendments to put those issues forward—this thing will not work. It will be absolute chaos across Ontario.

You know as well as I do that we were in hearings, and people came forward in the Kingston hearings who did not know until the day that they appeared before committee that the government had changed its approach to the kind of model that it would allow for service delivery. I thought that was absolutely shocking. As volunteers, they were enormously deflated to know that. One woman I spoke to had lost her husband recently, a farmer's wife. She was taking in the crops during the day, and at night she was going out and chairing long-term care committee meetings. She did not know that the government had changed its model.

What kind of an approach is it that the government has taken? People across Ontario have been working enormously hard over a lengthy period of time to come to terms with what is the most appropriate and legitimate means of delivering what everyone is committed to being an improvement in long-term care.

We will not be supporting this amendment. We are urging the government to look at models that will provide the flexibility and the opportunity to meet what real needs are to serve the individual people in Ontario. I urge that

you will accept our recommendation and our principles.

**Mr Wessenger:** As I'm listening to this debate and sort of reading this motion, the Conservative motion with respect to federated multiservice boards, I think what I find the most disturbing aspect about it is the fact that this motion, if put through, would in effect preserve the status quo. It would create no incentive for rationalization of the delivery system. It would in fact even provide further institutionalized support for that existing system, and in fact it's a statement that our long-term care system works well as it is, that it doesn't need any changes, that the service deliveries are working very well. That certainly was not what we heard with all the consultations. We certainly didn't get the message, when hearings were conducted, that the existing system worked well. It was indicated there were major difficulties with respect to the fragmentation of service.

I would suggest that basically this motion is the same as voting against the whole question of long-term care reform. So it's really saying, "We don't believe in long-term care reform" by putting this motion forward, because it provides no incentive to reform the system. I find that somewhat strange in that if we look at society in general now, what is happening, if we look at the private business sector, we see restructuring to provide more efficient service, more competitiveness; if we look at government, we're always being urged to be more effective, and we have to be more effective in delivering services and we have to rationalize services.

For some strange reason, when we come to the whole question of delivery of long-term care services, we have the Conservative position of: "Let's keep it the way it is. Let's not do any changes." I find that somewhat strange. Also what I find strange, in contrast to the attitude of "Let's not make any changes," is this news release that I saw dated today where it says "The Common Sense Revolution." I must admit that when I first saw it I thought it was a joke, because I said, "They can't be serious."

But just some of the dramatic changes they're proposing on social assistance, by contrast with how they deal with long-term care: They're going to take away social assistance benefits from 170,000 disabled or unemployed Ontarians. They're going to reduce the social assistance benefits. They're going to look back to R.B. Bennett as their example and we go back to welfare. What do you want, to have work camps again in Ontario? Of course, we know that's where Mike Harris would like to take us, back to the 1930s.

**Mr Jim Wilson:** If members would be so thoughtful as to provide me with both Mr Malkowski's copy of our press release on long-term care and, Mr Wessenger, if you'd give me a copy of those press releases, I would be delighted to read them on to the public record so that the people at home—thank you, Mr Martin, that's very kind of you. And we also have the long-term care one, so let's begin our discussion.

The PC release dated today is entitled—

**Mr Malkowski:** On a point of order: I have a copy of the press release right here, if you want to pick it up.

**Mr Jim Wilson:** I appreciate that. Someone handed me a copy of the press release also.

**Ms Carter:** This isn't a forum for reading out—

**Mr Jim Wilson:** Sure. It's a forum for talking about long-term care.

**Mr Jackson:** We didn't start it, Jenny.

**Mr Jim Wilson:** He attacked our position.

**Mr Jackson:** Apparently it was relevant when the Chair didn't rule it out of order when it was raised by the government party.

**The Vice-Chair:** Mr Wilson has the floor. Mr Wilson, do you wish to speak?

**Mr Jim Wilson:** It will take a minute, I do admit, but I didn't bring it up.

"Tory Health critic Jim Wilson and seniors advocate Cam Jackson were successful in strengthening the bill of rights for persons receiving community-based long-term care services during day two of clause-by-clause hearings on Bill 173.

"The PCs—committed to making the government's multiservice agency (MSA) structure less faceless and bureaucratic and more humane and responsive to the individual needs and preferences of long-term care consumers—were successful in building into the bill of rights the fact that consumers have a right to have service providers "be sensitive to and respond to" their ethnic, spiritual, linguistic, familial and cultural needs and preferences," says Wilson.

"The NDP commitment in this area continues to be suspect. In phase 1 of long-term care reform—Bill 101—the concept of sensitivity to these types of preferences was not in the initial wording of the bill and was added only after Tories introduced an amendment on the issue. With Bill 173, the NDP wording "take into account" just paid lip service to this critical concept," argues Jackson. "The government's wording required nothing more than workers taking a course on cultural sensitivity so that they could "take into account" these consumer concerns. The Tory amendment requires service providers to deliver services in a manner which is sensitive to and responds to things like religious preference."

"Throughout the public hearings, numerous groups expressed grave concern that existing community-based organizations which provide service based on specific ethnic, spiritual, linguistic, familial and cultural needs (eg, Saint Elizabeth Visiting Nurses) would disappear and that government-run MSAs would be incapable of delivering such specialized service," adds Wilson. "The PC motion responded to this concern very directly.

"The PCs will continue during day three of clause-by-clause analysis to amend the NDP's bureaucratic and monopolistic MSA model. The PC federated concept stresses partnerships among existing agencies to enhance flexibility in delivery of services at the local level in the hope that agencies like Saint Elizabeth Visiting Nurses, VON, Red Cross and commercial providers can continue to deliver these services."

End of press release.

Mr Malkowski talked about we didn't have consumers.

They're mentioned at least three times in this press release.

**Mr Malkowski:** On a point of clarification: This press release didn't mention the Ontario seniors' alliance.

**Mr Jim Wilson:** It didn't mention a number of groups.

**Mr Jackson:** It didn't mention Fidel Castro either.

**Mr Jim Wilson:** What did we have, Mr Clerk? I think it was upwards of 220 or more of groups.

*Interjection.*

**Mr Jim Wilson:** You're not listening. How can we go through a bill and you don't listen?

**1540**

**The Vice-Chair:** Mr Wilson, would you like to return to your motion?

**Mr Jim Wilson:** It mentions consumers. The whole point of it was not what was expressed by Mr Malkowski to our public audience; it was the exact opposite. We strengthened the bill of rights. You voted for and helped us with that amendment. For him to raise it a few minutes ago in a negative light is just a falsehood, and that's what I took offence to. It's a good-news press release for consumers. That was the whole idea of it. That's what it says. It's on the public record now and people can read it themselves.

Secondly, Mr Malkowski and Mr Wessinger bring into this debate a press release by Mr Harris today. It says:

"In a major address to Ontario's social workers later today, Mike Harris will detail the specific steps a PC government will take to reform the welfare system in Ontario.

"Among the key reforms"—and these are part of our Common Sense Revolution—"are:

"Removing 170,000 disabled or unemployable Ontarians from the welfare rolls;

"Setting benefits to 10% above the national average;

"Mandatory 'workfare' and 'learnfare' for able-bodied recipients;

"New programs for literacy, nutrition, parenting and child care;

"Computerized ID systems to combat mismanagement and fraud."

"Harris's address to the Ontario Association of Professional Social Workers will begin at 4 pm at the Primrose Hotel, 111 Carlton Street, Toronto, on the 23rd floor."

I appreciate the opportunity to make that plug.

**Mr Sullivan:** Does it say what he's going to do with agriculture in the meantime?

**Mr Jim Wilson:** You've got 15 minutes, for people in Toronto, if you want to try to get to the Primrose Hotel by 4 o'clock to hear Mr Harris. I'm sure they'll enjoy it.

**The Vice-Chair:** Mr Wilson, do you wish to return to your motion? We need to move on.

**Mr Jim Wilson:** Okay. That's the end of that press release.

I just will briefly say, the reason we're removing 170,000 disabled or unemployable Ontarians from welfare is because it is simply demeaning that past governments have forced these people to go on welfare in order to live. We will set up a separate, more dignified system for those individuals. Their benefits are not cut and their rates are guaranteed at current levels, for those people.

**Mrs Sullivan:** On a point of order, Mr Chair: I wonder if the Chair would like to advise the member to speak to the point of debate.

**The Vice-Chair:** Mr Wilson, we do have several more speakers on this.

**Mr Jim Wilson:** That's fine.

**The Vice-Chair:** You did move a motion and you should be speaking to the motion.

**Mr Jackson:** On a point of order, Mr Chairman: The Chairman is charged with an immediate ruling on a given point of order. I was quite surprised that when Mr Malkowski began reading his press release, you were allowing people to read directly from a text. That's fine. But when the parliamentary assistant began reading an unrelated press release, I had hoped that the Chair would have intervened. He chose not to. For that reason, the Chair is required to allow us to clarify those matters that were raised, and we're prepared to do that.

**The Vice-Chair:** You have.

**Mr Jackson:** I want to thank the Chair for allowing us the opportunity to clarify, but I suspect when those matters are raised is the time we should have indicated that they were a bit outside the ambit of the discussion.

**The Vice-Chair:** Yes. You're quite correct. From the point of view of getting on and discussing the important issues in this bill, we should have done that. Mr Wilson, have you completed?

**Mr Jim Wilson:** Thank you, Mr Chairman. I want to clear up that 170,000 figure. It's good news for people who are disabled and unemployable in this province.

Mandatory workfare and learnfare, in case the members haven't talked to Mr Silipo recently and the federal Liberals—it strikes me that all parties are now talking about what we've been talking about for years.

**Ms Carter:** But voluntary, not mandatory.

**Mr Jim Wilson:** I do admit it's mandatory. We are sending a very clear message that able-bodied people in this province will not be allowed, if we form the government, to stay home and collect benefits. They will be required to do something.

**The Vice-Chair:** Thank you, Mr Wilson, for your comments. We will now—

**Mr Jim Wilson:** Back to the bill, but I am within order and you have no right to do this, because Robert's Rules says that if it's raised in debate, I'm allowed to debate it.

**Mrs Sullivan:** We don't use Robert's in this House.

**The Vice-Chair:** Mr Wilson, you have done that. You've responded lengthily.

**Mr Jim Wilson:** We do use Robert's. The Legislative Assembly Act is based on those.

I want to then talk about a couple of points that were also raised regarding this amendment and our attempt to improve the government's bill, that is, the charge that's been made that in the case of long-term care services, this amendment is not a radical change from the status quo. I accept that charge. This amendment is not a radical change, but I have never argued, because I've had an open mind on the concept all through long-term care reform, that the system is radically broken. I have not argued that, and therefore I'm not proposing radical change. I don't think the VON is doing a bad job. I don't think the Red Cross is doing a bad job.

I do agree with the government's stated objectives, and that is, the system needs to be better coordinated. I do not agree, nor do my colleagues, with setting up a monopoly system for the delivery of services and destroying what's out there.

It couldn't be any simpler. Therefore, yes, it is not a radical change. It is a commonsense approach to trying to fix what actually is broken and not trying to destroy a system that is delivering services and a system that is serving and has served Ontarians very, very well. That is the point.

So I accept the charge. I think the system needs some firm direction, and this motion tries to give them some firm direction but also allow them the flexibility and requires them to get back to government about what's best for their communities.

Yes, it doesn't propose that we destroy all the good work and the volunteers and the fund-raising efforts that are going on, because we've seen this sort of social engineering in other provinces and it's not working and you'll see them change. Quebec, for example, is not happy with its system, and you'll see probably change in the next 10 years evolving back.

With that, I will leave this part of the debate. I've done the best I can to explain our federated model. I remind people that little old Jim Wilson of the Tory caucus didn't make this up, that a number of groups specifically requested a federated model. Most groups didn't argue before this committee that the system was radically broken, but all groups admitted it needed fixing in some specific areas, and you've taken an elephant gun to a system that simply needed a bit of fixing of some problems regarding coordination and access.

You've decided, in your own image, to tear down the current system and start over with a new NDP system, and I'll tell you, if it's anything like any other systems you've set up in the last four years since coming to office—the public of Ontario rejects your management of this province, and they will reject and are rejecting your management of the long-term care system and the reform of that system.

**Mr Jackson:** In responding to the PC motion, which is a rather large one—it's probably the largest single motion that's been tabled to date, but it covers a fair bit of territory because we want to make sure it's abundantly clear that this section, as proposed by the Progressive Conservatives, would not be as restrictive as is being suggested. What we're asking for here is simply that we have a certain amount of flexibility so that local organiz-

ations can come together and determine the shape of their MSA.

I won't go over the turf again, but as I indicated yesterday in debate, we were moving along towards a federated model when the Liberal government seven and a half years ago first started planning and developing concepts around long-term care reform. It wasn't until the last six months that the most recent NDP Minister of Health dropped the bombshell that we were fundamentally going to shift to this brokerage model.

So I want to indicate at the outset that before the Liberals condemn the flexibility called for in this motion, it follows very closely the kind of model the Liberals were moving along when they were developing local determination, flexible models that could range from a direct delivery model, which the government seems to feel we should have a steady diet of, to and including a federated model where people come collectively and over a period of time. Certain agencies phase out or merge, certain agencies say, "Look, there's enough coverage going on in home care; I think we'll get out of the home care business and we can do a better job doing blood transfusions," or "We're going to get out of the direct delivery of meals because it's too expensive and we'll focus more on direct nursing care in the home." Those are the kinds of models we thought we were moving towards.

1550

There is a whole group of citizens that did not respond to us during the hearings. Those are persons responsible at the municipal and regional government levels. We know that AMO indicated it was not consulted about this fundamental structural change in the whole direction of long-term care. I know a lot of us, because we were on this committee together, most of us in this room today, were concerned that AMO was not consulted. That raised serious concerns about the general level of awareness and understanding not only of municipal politicians but of staff who provide health-related support services within their communities, their towns or their regions.

Liberal member Bruce Crozier, MPP, was kind enough to forward to me a copy of several resolutions from several municipalities in southwestern Ontario. I have a resolution from the town of Essex. I have another one he's given to me from Belle River, another one from the town of La Salle, another one from the town of Amherstburg, all resolutions from the local councils and governments pleading with this government to either do one of two things: Delay this legislation, which I don't necessarily think is a great idea—

*Interjection.*

**Mr Jackson:** Mr Martin, just hear me out for a second—or structure it in such a way that it has the flexibility built into it so that a larger group of people can determine how to most efficiently provide this service.

The strongest point I was hearing from both Mr Martin and Mr O'Connor was on the notion that our Tory motion contrasts with the government's motion in the way we would approach this issue, and I agree. I agree that the NDP's approach is quite different from the

approach taken by the Tories. There are several examples of it.

I could cite, for example, Bill 101; Bill 101 was the first phase of long-term care reform. Mr Martin and Mr O'Connor said they were providing it in a more cost-efficient, cost-effective way. I beg to differ with them. If they aren't aware of it, your first phase of long-term care in Bill 101—and Mr Quirt is here. He was on the road with us for a whole year doing Bill 101, and he was on the road with us for six months doing this bill. We know today that we still haven't ironed out all the bugs with Bill 101. We still have not been able to give confidence to consumers of services that the costs associated with staying in a nursing home or a home for the aged have been stabilized. We've had three, and in some cases four, different calculations proposed.

**Mr Martin:** Give it a chance. It's been a year.

**Mr Jackson:** My point to Mr Martin is simply this: If the government is going to wing it with how this legislation is going to be implemented, as it did with Bill 101, it is going to find out that it's going to come at great expense. Bill 101 is just one example of how the government felt it was going to make radical change, restructure. We know the \$150 million you were seeking was to come from the user fees to the senior citizens, which Jane Leitch, incidentally, and the united senior citizens were quite disturbed about. We know that is one approach where, even when the government set it all out in legislation, here we are a year and some months later and the government still hasn't ironed out all the bugs and consumers are getting hurt by it, and the government is spending money it didn't budget for because it can't get the bugs ironed out.

**Mr Martin:** Not true.

**Mr Jackson:** There's a second example, and probably the more prophetic example, as to how the government is about to change in the restructuring, because the elements are completely parallel here. It's the way the government has approached the whole issue of providing day care service. Mr Martin used that as an example, with some degree of pride, of how he's able to show that that's the approach of the NDP versus the approach of the Tories.

**Mr Martin:** I didn't mention day care.

**Mr Jackson:** Yes, you did.

**Mr Martin:** No, I didn't.

**Mr Jackson:** You did, then Mr O'Connor did. The fact is that when the government decided to restructure long-term care, it is going about it exactly the same way it decided to restructure day care services within the province of Ontario.

First of all, they held out a promise or a commitment that they were going to remove the private sector or commercial operators.

Second, they said they were going to up the salaries of those workers who were unionized or in the not-for-profit sector and they would burn or disregard all those women workers who weren't in unionized settings or who were with commercial operators.

Third, they promised that where there were conversions to the government's approved process for day care, they

would be compensated. Rather than putting money into direct service, they had to come up with millions of dollars, approximately \$100 million, to convert and buy out a perfectly viable, efficient private sector, commercial sector, in order to make it an extension of, an arm of, government.

After two years of this plan, we have found a whole series of day care centres in this province that, upon the faith of the government, were told they were going to get paid a certain amount of money but, when it came time to convert, the government welshed on the deal. I'll give examples, I'll give the cities and I'll give day care centres, if they wish.

It strikes me that the NDP government is offering the same kinds of assurances to not only the commercial deliverers of home care service but also to the non-profit deliverers of this service, offering them the exact same promise and formula they offered the day care sector.

The government might argue, "Maybe we welshed with the day care sector, but we won't welsh on the long-term care sector." I think the truth of the matter is that if they're going to do it to one sector, they'll do it to the other, because the factors are all the same.

One of the reasons Bruce Crozier sent me this information about the towns of Essex and Amherstburg and so on is because you're not going to fool those municipal politicians a second time. They realize that the government was phasing out private day care centres just the way it's now going to propose to phase out private home care providers. And what did they learn from that experience? They learned that these were perfectly viable, efficient deliverers of service in the community. They were paying municipal taxes, they were paying a series of business taxes to the municipality, as well as property taxes, income taxes and a whole host of other taxes and revenue to a given community.

So municipal politicians are saying: "Whoa. What's going on here? All of a sudden I'm being told there's this 80-20 formula, and not only are we going to phase out some of our private commercial operations, we're also going to phase out some of these other institutions, some of which are paying taxes."

Municipalities have a legitimate right in this province to say: "Before you do this, you should have consulted us. Now that we've twigged to it, will you please at least allow us to develop a model?" as Amherstburg has said. I'm not going to read into the record the entire resolution, but within the body of the resolution from this municipal council, it suggests that there are opportunities for the municipalities to participate in ensuring that the most efficient model and the most cost-effective model is developed within their region for the purposes of their services.

Day care therefore has become the precursor to what the government is about to do with long-term care. York region, for example, has said no to the government's formula on day care because it puts out tax revenue and it turns it away. Other municipalities have agreed with the government's plan, and they have every right to. But it strikes me they're not giving the municipalities the choices here. They are simply saying to them, "There's

going to be this one model and these are the repercussions."

**Mrs Sullivan:** You've only put forward one model too.

**Mr Jackson:** No, I've indicated to Ms Sullivan, who knows well enough that the wording in this motion offers the flexibility to determine any kind of model.

**Mrs Sullivan:** You're just trying to back out of what you put forward, Cam.

**Mr Jackson:** Ms Sullivan is still quite concerned about the fact that her leader has cut off her legs in these discussions because she has been on record on Robert Fisher's Focus Ontario and with Steve Arnold of the Hamilton Spectator that they are going to repeal this legislation. I tell you, that's irresponsible of the Liberals. Rightly or wrongly, the province needs long-term care reform. We need it. I don't agree with the government's approach, but I agree we need it. Lyn McLeod has simply said, "If it ain't my way, it ain't going to happen." I'll tell you exactly what the agenda for the Liberals is. The Liberal agenda is, "We'll study it for two more years and then we won't have to fund it." That's their game plan, and they're not going to kid me any differently.

1600

**Mrs Sullivan:** Untrue. You've put forward a single template that's absolutely inflexible, and you're trying to talk your way around it.

**Mr Jackson:** When the Liberal Party enjoined the NDP with its strategy for day care conversions in this province, it was pretty clear where it sits on this whole issue of how we develop and protect key services in our communities.

I want to proceed now to what the implications are going to be in the short term versus the long term. One of the things missing from this resolution is that we do not say everything has to be in place, locked in, firmed up, hammered down within four years, as the government has suggested. We see an evolutionary process here, and I'll tell you why we see an evolutionary process.

We are about to spend millions of dollars, as we did with the day care, unnecessarily converting from one system to another. There is a much better, more efficient and more economic way for us to do that conversion, and it can be done fairly simply. If we again look at the model and what happened with day care, we can see how it's about to occur here. I'll use my own community of Halton, which Ms Sullivan is familiar with.

Under the government's model, we've been told there will be less total human resources put into the system because we've been told there'll be a short-term dropoff of volunteers. We understand there will be a large fiscal commitment of dollars at the front end of this, dollars that are going to be spent on buying out severance packages from a whole series of agencies that have to convert because of the 80-20 rule, a whole series of dollars that'll have to be spent out as we transfer the vehicles from the VON, the capital equipment from the Red Cross and so on and so forth, plus there's this huge investment of dollars that is required.

I have to say, any time we build a new bureaucracy,

we have to fund it to establish it; it's always more expensive in the front year. We have to open office space, while we're going to close down office space down the street. We're going to bring in new equipment and new computers and new software, while we're going to be throwing out computer software and computers down the road at the Red Cross. We're going to be bringing in leasehold improvements to long-term leases for this new government agency, and we're going to be paying a premium for it too.

I want to use Halton as an example, because this is what happened. In Halton region, where I come from, in fact in the community of Burlington, nine years ago we identified that these small agencies, the ones the government says there are far too many of and have too high an administrative cost—in the city of Burlington we worked out an arrangement with the Rotary Club of Burlington, and I want to mention them for the record, because they had the vision and the understanding of how we can better provide social services in a community. The Rotary Club of Burlington said, "We will provide you with a building, we will provide you with facilities, if you can bring four, five or six agencies together under one roof and share common telephones, share common space." This is going on in Burlington today.

The tragedy is that under this legislation, with regard to that space that was donated to the Red Cross and to the women's shelter and the women's abuse line, to Meals on Wheels, to a whole series of support groups that share one common boardroom and one single facility, we now have to say, "Sorry, Rotary Club, take your building back, because we now think the taxpayers of Ontario should go and build another building down the street and put civil servants in it."

I have to be fair. The situation in Burlington isn't occurring everywhere in Ontario, unfortunately. Perhaps if every community in Ontario was doing what they're doing in Burlington on this one point, just to stress this point of the millions we'll put into bricks and mortar and computers and new carpets and new drapes, which we don't have to spend—I'd rather see that money going into my grandmother's living room to give her additional support so she can live independently.

Maybe we failed the system because we didn't compliment the Rotary Club and get the Red Cross to tell the other Red Crosses, "Why don't you do this?" Maybe all we needed to do was to shake them up a little and say, "If we have a model which tells you to move in this direction, you'll do it."

We did it in Burlington because we believed in it, but we're now going to throw all of that out. I'm trying to suggest to you that I wouldn't be upset if in the whole province of Ontario, every region in Ontario, wanted to go on the government's model, which was a direct government agency providing the services with the nice, well-appointed board.

But what's going to happen is that they will deny the citizens of Burlington a wonderful system we already have in place now, and that's wrong. I'm trying to plead that you at least give us the language in this bill so that you'll let Burlington have its MSA without wasting

taxpayers' dollars. You may save dollars in Wawa, but you're going to lose hundreds of thousands of dollars in Burlington that you don't need to spend.

This is an important issue because it is now becoming a more important issue in our municipal election. It's now become a major issue—

**Mr O'Connor:** On a point of order, Mr Chair: Mr Jackson just mentioned the fact that there would be an appointed board. I believe he's referring to the MSA, and there is no appointment to the board of the MSA. It's a misconception, and I appreciate the opportunity to put it on the record. Clearly, within the bill there is no appointed board.

**Mr Jackson:** Mr Chairman, is that a point of order or is it a point—

**The Vice-Chair:** Thank you. A point of information.

**Mr Jackson:** I apologize. I didn't know the government had withdrawn that clause which said the minister shall override any of the appointees. I didn't know you'd withdrawn that, and you'll have my full support for withdrawing that. I did not know that the initial board, appointees, has been withdrawn from the bill. I want to thank Mr O'Connor for clarifying that, and I'm sure we'll have his support—he's on the record—when that comes for a vote in that section, because surely you wouldn't have misled all the people watching on TV today that the first board isn't appointed.

**The Vice-Chair:** Mr Jackson, would you like the parliamentary assistant to clarify that point?

**Mr Wessenger:** I can understand Mr Jackson's confusion, as his motion provides for the government to appoint members to the multiservice board.

**Mr Jackson:** We still haven't gotten a clarification. Can the parliamentary assistant tell me, does the minister reserve the right to review the appointments and finalize the appointments in the first term?

**Mr Wessenger:** No. The minister has no rights with respect to appointments to multiservice agencies.

**Mr Jackson:** Great. You've withdrawn that motion.

**Mr Wessenger:** There never was any such motion.

**Mr Jim Wilson:** Mr Chairman, can I clear this point of order up? Can I clear up the confusion? I guess what's been somewhat unclear—

**The Vice-Chair:** Mr Wilson—

**Mr Jim Wilson:** No, on the point of order that was raised.

**The Vice-Chair:** Quickly.

**Mr Jim Wilson:** The first board must have to be appointed in order to get started so you can then have elections for your non-profit corporation, so there is an appointment. We have a motion, and one of the reasons is that we want to ensure that appointed board doesn't go on indefinitely until you get your non-profit corporation or co-op up and running. There is a provision here for an appointment initially, Mr Chairman. How else do they get started?

**Mr Wessenger:** Mr Chair, perhaps we could just read in what it says:

"The federated multiservice board shall be composed of...

"(b) the prescribed number of representatives of other service providers and consumers in the geographic area appointed by the minister."

That's pretty clear. This is the Tory motion, the Conservative motion.

**Mr Jim Wilson:** But could you please read the clause before that? That's how we'll get consumers on the federated board. I agree. The local communities will put forward the consumers they want and the minister will have to appoint them; that was the only legal way we could do it. But the service providers, who come together in a partnership, recommend and appoint their own representatives.

**Mr Wessinger:** I'd like to also clarify. I think the statement was made that under our bill we would appoint the first members of the board.

**Mr Jackson:** Point of order, Mr Chairman: When do I get the floor back?

**Mr Wessinger:** That is not accurate. We would never appoint the members of the board.

**Mr Jim Wilson:** Well, how do you get started?

**Mr Jackson:** A point of order.

**The Vice-Chair:** Yes. Go ahead.

**Mr Jackson:** Thank you, Mr Chairman. Now, if I may continue, I had indicated during the course of my comments what my concerns were with respect to the current NDP model, with the huge ballooning of costs that will go into conversion and not into people's living rooms and into their homes, where they need this service. I've used several examples of the acquisition of large office spaces, I've used the example of the acquisition of large amounts of equipment, I've used the example of them buying the materials from the VON and others and I've used the example of them taking moneys and paying them to people so that they'll walk away from their jobs.

1610

What we're trying to suggest within this model is that this model will allow for forms of conversion on an evolutionary basis. They are done by a federated model coming together, as they have done in Burlington, as they did in York region, as they did with one of the services in Durham, I'm advised. The fact is that you will have more total overall human resources to work with. The volunteer sector will leave in the short term and come back later probably, but we've been told that we will not have any change in the number of volunteers. So our human resources, with the number of people helping the system, will be better.

We keep and preserve and have time to negotiate with organizations like the United Way. The United Way has served notice that it is going to be withdrawing fiscal support for organizations that are disbanded and not providing the service and that those dollars that are now going to the Red Cross homemaker program will not automatically resurface and be handed over to an MSA, to a government agency or to this new board that the NDP is proposing. So we keep intact fiscal dollars.

Whether they come from volunteer contributions, whether they come from contributions through the Charitable Institutions Act, whether they come from direct government service, we keep that money in the system and we manage through a period of change.

Frankly, the most significant issue in terms of our motion is that it maintains and improves upon the level of service to clients and we don't experience the drop in service. You're going to have a drop in service because you can't put money into rent, into buying cars that are already out there, just like the government realized what happened with day care. I want to tie this back to the point with day care. At the end of the government's experiment in the wilderness with day care, it found out that after \$100 million was spent, it had fewer day care spaces, it had fewer people actively employed as child care workers in this province and therefore it had fewer children and families receiving the service.

So on the one hand the government will put more money into this system. That's the way it's designed. But at the other end we're going to have a whole lot of people unemployed and we're going to have a whole lot of senior citizens experience a reduction in the short term, because that's exactly what happened with this approach. It's a radical, invasive, major turnaround change, and I've been stressing for three days this was big news, it was a huge surprise and it was a 180-degree turn. It was dumped on this province unceremoniously by a press conference by the minister that all of a sudden, whatever her rationale was, we are no longer going to broker services in this managed plan change environment so that nobody gets hurt and taxpayers get value for their dollar.

Instead we're going to go with this radical turnaround, and that's why you're going to be receiving, as a government, more and more of these resolutions from municipalities, why today the mayor of Burlington, Walker Mulkeiwich, a prominent card-carrying NDPer, is out there in Burlington defending the government's bill. Why? Because it's going to put a couple of more private centres out of business and they're going to pay less taxes, and the person running against him for mayor is saying, "I disagree with that."

That's a healthy part of our debate, and yet you're going to rush to get this all rammed through so that municipalities will wake up one morning and realize: "How did we let this happen to us? Why in Burlington, when we built a coalition of services for less total dollars and we used public contributions to build an infrastructure of support for our seniors? We're providing better and more services because we did it and we're going to walk away from it and turn it down."

The part that offends me, and why this motion is so important to the Conservatives, is that it will at least allow those people to reshape it into a more efficient way. The Price Waterhouse study, regardless of what is said about this study, was a very simplistic approach without all the details. We all know the difficulty when we start quoting statistics and why we get into difficulty quoting statistics. But that study was deficient in terms of understanding the kinds of opportunities to reduce over-

head without phasing out an organization.

What's being proposed by the government's recommendations, and apparently with the support of the Liberal Party, which is going to vote against the Tory flexible model, is that we're going to move directly to the harsh reality of the cuts that are to come.

**Ms Carter:** What cuts?

**Mr Jackson:** What cuts? Ms Carter, I was almost finished, but you've asked me a question, and I'll answer it. What cuts? I suspect that when you were with us on the road you heard from the Red Cross, which said, "There are going to be cuts to our staff when you phase us out." Apparently there must be some form of cuts because your parliamentary assistant offered some assuring words about, "We'll come up with money to pay for your severance."

**Mr Wessenger:** No. On a point of order, Mr Chairman: I don't recall making any such statement.

**The Vice-Chair:** Thank you. Proceed.

**Mr Jackson:** But I'd like to understand. Is the parliamentary assistant's failing memory his point, or is it the exact language I used?

**Mr O'Connor:** Wishful thinking.

**Mr Jackson:** Are we offering no assistance for labour conversion here?

**Mr Wessenger:** It certainly is not accurate as far as I am concerned. It's certainly not an accurate statement.

**Mr Jackson:** Is there not a labour conversion?

**The Vice-Chair:** Please.

**Mr Jackson:** Sorry, Mr Chairman.

**Mr Wessenger:** That's not an accurate reflection of the statement that was made. The reality is that with our amendments, under the labour amendments, we are providing for the transfer of employees to the MSA and the avoidance of the severance costs situation.

**Mr Jim Wilson:** No, no, no. No, you have a severance provision in there too, under the Employment Standards Act, that you do anticipate having to pay some severance.

**Mr Jackson:** I'm sorry. I was present, I believe it was in Hamilton, when it was raised by the Red Cross, "Who will cover our costs of severance?" Ms Carter wants to know what the cuts are, and that's a fair question. As I recall, in Hamilton the parliamentary assistant indicated that there would be recognition of some of those costs. The Red Cross seemed quite pleased that there was going to be some recognition of this.

Are we now saying, if the Red Cross is told, "In one month, you're no longer the service provider for home care and therefore we no longer need all the space that you've got," that "You no longer need to honour the contracts that you've signed or the vehicles that you own"? My understanding is that if we were to wipe that out or cause their loss of business, there are laws in this province to protect those workers because the employer, in this case the Red Cross, doesn't have the money to pay the severances. They could basically just say: "Hey, we're a non-profit corporation. Sue us. We're out the door."

But the irony here is that it's an NDP government that's forcing them to lose their jobs. I only assumed in that, and I think the Red Cross were asking, "Since the NDP caused me to have to move to another job, if I don't get that job, you're going to pay me my years of service," and so on and so forth.

To put a finer point on it, I recall, because I got involved in the discussion and I said, "Are you prepared to assist the Red Cross with budgeting for that?" If I'm the Red Cross and I have four employees who are going to turn 60 and they're going to retire, then I'm going to give them a form of a severance for their years of experience. I budget for that. But if I take all 400 employees of my Red Cross who are doing home care and they're no longer doing the service, the law in this province is that they get a severance. Now are you saying that you're going to burden all of these organizations not only with closing their doors but with all these costs in accordance with laws in this province?

**Mr Wessenger:** Well, now that I have an opportunity to answer that question, I do recall what I said on many occasions, and that was before our amendments with respect to the labour situation, which now provide that comparable employment will be offered and, where comparable employment is offered, there will be no right to severance pay. That's right in the provisions with respect to the labour situation.

1620

Previously I had said that it would be a requirement by the minister that any MSA would develop a fair human resources program and part of that human resources program, part of the principles of it, would be to incorporate into the MSA those employees in the community who are presently delivering those services. That's basically what I said on the previous occasion and that should be clarified.

With respect to the question also that there may occasionally be some administrative people who may not have positions found for them, they'll be subject, as I understand, to HTAP, Hospital Training and Adjustment Panel, provisions.

In addition, we have the four-year transition phase which allows for an orderly transition to the MSA model. We have a local planning process to develop the MSA model and all these factors are obviously going to be involved in developing such a situation, so it's a scare tactic to say there's going to be a major loss of jobs. In fact there will be more jobs in the system, particularly for those delivering a service, particularly those people who are delivering services such as homemaking or nursing services. There will be more jobs in these areas.

**The Vice-Chair:** Had you completed, Mr Jackson?

**Mr Jackson:** Ms Carter wanted to know what were the additional costs, and I'm sure the government is aware—

**The Vice-Chair:** She did not address that question to the Chair, however.

**Mr Jackson:** Thank you, Mr Chairman. There is cost associated with the setup and the startup of these MSA units. What the current legislation as it is before us

suggests is a whole series of groups that cannot be MSAs, which almost invariably requires the creation of an entirely new infrastructure.

For that reason, we're turning our backs on existing cheap long-term leases in facilities, capital equipment, telephone lines, a whole series of things. I suspect that although the government hasn't given us any costing or cost analysis, certainly the township of Amherstburg and several others have indicated their concern about, "We can't get any straight answers from the government with respect to what the costs will be."

Those are the costs I was referring to: the human resources conversion, the physical plant capital cost conversion and the ongoing operational cost that would be associated with the government's plan. I think that if the government was a wise shepherd of the resources of the people, it would realize that the approach it took with day care won't work, that it'll be too costly. In fact they're trying to replicate that here and it will be filled with huge bureaucratic costs and fewer direct service access points. For that reason, we have presented this series of amendments, rather lengthy ones, but it would allow for flexibility in the model.

Thank you, Chairman. I wanted to get those points on behalf of those municipalities that were frozen out of the process, on behalf of those municipalities that would like to participate in the process, and I urge members to look for a more flexible model than is contained in the current government's legislation.

**Mr Malkowski:** I'd like an opportunity to respond to some of the comments by the member from Burlington, Cam Jackson, in regard to his motion, the Progressive Conservative one, and to remind the two Tory members who are here that their motion talks about the number of representatives who are service providers selected by agencies. You also mention in here representatives of service providers and "consumers...appointed by the minister."

This is your motion, but there's nothing in the motion per se to talk about appointments of consumer reps from consumer organizations. I have a problem with that; that's my point. It's problematic. I have difficulty accepting the way this talks about—you say you're not going to do that, in other words, obliterate consumers, but in fact you are. The Ontario senior citizens' alliance is not mentioned here. We want appointments of representatives and we want to make sure that consumers are represented. It's not mentioned in here at all.

My second point: If you remember and we look back in history, under the Tory years where we talk about long-term care and supervision, service providers, it was big institutions, lots of nurses. Big institutions were built, hospitals, all that business, and senior citizens I believe suffered because they really didn't have a whole lot of choice. Consumers and the community wanted in, to have some ownership of those things. Our government has a commitment to change the Tory system, and I believe that you over there are afraid of the unknown and you are afraid for fear's sake. You're afraid of difference and you don't want to change. You advocate the status quo. The status quo stays: no change, folks.

So it looks like you're not very supportive at all of representatives from consumer groups to be represented when over one third of the consumers who have participated in this need to be heard from, and you reject that. You listen to service providers and you want them to have total control over the lives of consumers. That I believe is oppressive and that's what we would see would happen under your motion.

Keep in mind the concerns that were raised by the Ontario citizens' alliance, who came to this committee and we heard directly from them. Their priority was they wanted respect and they wanted representation of their own experience because they lived their experience and they wanted a voice on this. So I asked, on the question of service providers, for example, like VON or Red Cross, "Do you have any formal consumer mechanism there?" They had to admit that, no, they didn't really have a system for that, that they needed to work on that. In private, for example, some of the service providers have also said that they have no formal consumer mechanism to have those people to give feedback to their organizations.

Therefore, it's problematic and I have difficulty accepting the Progressive Conservative amendments. That's why I'm making a point about your press release or in your comments, that what you say here, you don't mention at all people like the Ontario senior citizens' alliance. There's no mention here at all. You talk about service providers, but you don't really respond to the needs and the concerns raised by consumers and senior citizens. Where is the mechanism for people to offer feedback?

You make no comment on that. I would challenge you. You make no comment on that. So I'm sorry, but your comments—I mean, you can sit there and deny and play games all you want, but in point of fact, it will be the status quo, and you're entrenching that.

We believe, our government strongly believes, the New Democratic government believes that it's time for consumers to become involved—they are—and to make sure that one third of those consumers are heard from and have a say on the boards. This is vital. This is an important point that our government believes in.

I would ask you over there, are you really that afraid of change, positive change, positive change that would include all these consumers, one third of consumers on the boards? Are you really, truly afraid of that? Why can't you listen to the concerns of senior citizens who came before us, the senior citizens' alliance? Why do you ignore them? That's terrible.

This history of senior citizens suffering under the Tory years, quite frankly, when the Liberal government tried—the Liberal government may have tried hard, but a lot of times it was talk, and, oh boy, they could sure wind a tune and they could really talk beautiful language, but when it came down to it, nothing happened, folks. And that's what you'll get under a Lyn McLeod government, a philosophy of lots of talk and no action.

I know that Mr Mike Harris has all the rhetoric down, but where's the action, folks? Where does the buck stop? Talk is beautiful. Rhetoric's great. Flowery language and

flowery speeches? Oh, very nice. Very nice. I would challenge you: Where is your commitment to the consumers? Where's your commitment? That's problematic for us from what I can see here. We don't accept this proposal at all. Where are your principles over there? You talk about consumer participation, but where is it reflected in here?

**Mr Jim Wilson:** Can we answer this question?

**Mr Malkowski:** I challenge you. Where are the consumers in all this?

**Mr Jim Wilson:** Mr Chairman, I have to answer this direct challenge if I may, quickly.

**Mr Malkowski:** I have the floor, I believe.

**The Vice-Chair:** Mr Malkowski.

**Mr Malkowski:** Thank you, Mr Chair.

1630

**Mrs Sullivan:** On a point of order, Mr Chair: I wonder if we could have all-party agreement to limit comments on major sections of the bill to X number of minutes per speaker. I think this is a significant bill. We have been wandering around the fence and our party has in fact been disciplined in terms of the debate. We've been speaking to the issues; we haven't been reading self-serving news releases into the record. We have been debating the issues that are associated with what affects every person in Ontario who requires long-term care.

We've been getting an awful lot of baffle-gab and blathering and rhetoric from the other two parties. The parliamentary assistant, to my understanding, Mr Wessinger, is to be carrying the bill, and surely we don't need all of this extraneous verbiage with respect to issues that are not associated in fact with the sections of the bill which are under debate.

**The Vice-Chair:** Thank you for your suggestion. You will be the next speaker when Mr Malkowski has completed and we'll start with closer time allocation. Mr Malkowski, continue, please.

**Mr Malkowski:** Thank you. That's part of my point. Once again, we see lots of language and lots of ideas over there, trying to look like they have a little halo over their heads, but in point of fact, "Good try, folks, but you fail."

A point of the PC motion is that the concerns we see—once again, I must re-emphasize no mention, no representations of appointments of the consumer organizations; for example, the Ontario senior citizens' alliance. My point is, why are you afraid of positive change? Why are you afraid of that? Why do you want to entrench the status quo and let private companies take control of vulnerable people and senior citizens for their own profit? Why would you want to see that happen?

*Interjections.*

**The Vice-Chair:** Order.

**Mr Malkowski:** In point of fact, you have no formal consumer mechanism to be involved; it's only service providers. There's no mechanism in here for consumers to be involved.

All I'm asking you to do is be reasonable and listen to the recommendations from the Ontario senior citizens'

alliance. They have come forward and lobbied, they've been both to the Conservative offices and the Liberal offices and they've told me how frustrated they were. There's no concern raised to them.

Our government has been open and accessible and has been listening to the senior citizens in a real manner. These are real people who have lived experiences and we have a real mechanism to make sure that we hear from them. That is my point, that we are accountable, and that's part of the foundation of this legislation, to increase this one third of consumer representation and bring balance. Why you focus consistently on providing service providers with more power is beyond me.

What I want to ask the Progressive Conservatives who sit over there—and they're all upset now and they're all talking away, but this is an important point: We want to increase the participation of consumers. It's an important point.

I will challenge you over there. If you're willing to reconsider your position and include one third of participation of consumers to be appointed, I'd be happy to see you do that.

**The Vice-Chair:** Thank you. Mrs Sullivan. Oh, sorry, did you wish to speak at this time? You're next on the list.

**Mrs Sullivan:** I am going to give my speaking time to Mrs O'Neill, who hasn't had an opportunity yet to address this section.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I think I was on the list, Mr Chairman, but I have been here for the two and a half hours this afternoon and I don't know the proper word to sum up what's been happening, but I do think any consumer who has been watching this afternoon must be somewhat disturbed. Anybody who is looking for long-term care reform in this province must be disturbed, because I don't think we've been getting down to the meat of the matter; I'm sorry.

I will say, at the beginning, that I will not be supporting the Tory motion before us. It is as prescriptive as Bill 173, maybe even more so. We have 31 district health councils in this province that have not yet spoken on this matter. They have been mandated, they have been given direction—in some cases very, very definitive direction—but they have not yet presented their case about what they think is best for their communities, and I don't think we're ready to tell them how to do it. They are doing a very good job.

**Mr Jim Wilson:** That's exactly the point of the motion.

**Mrs O'Neill:** I will speak to the organization that Mr Malkowski seems to be speaking to. I think he's talking about the Senior Citizens' Consumer Alliance for Long-Term Care Reform. They, I will suggest, do not totally endorse Bill 173. We have met with them several times. They have 15 concerns about Bill 173, and this morning I was with the seniors down at the St Lawrence Centre—there were 500 seniors there; 300 turned away—and they too expressed concern about Bill 173. They were expressing a lot of concerns, but Bill 173 was thrown in: concerns about user fees, concerns about what changes are

going to take place regarding the way in which they're going to—

*Interjection.*

**The Vice-Chair:** Order, please.

**Mrs O'Neill:** And they certainly are concerned about the role of volunteers, because many of them are volunteers.

**Mrs Caplan:** It's not going to work.

**Mrs O'Neill:** Consumer participation is going to take place, but I'm not sure that it's going to take place in the way the government members are describing it. If you look at the boards of the MSAs, we know they will be elected from membership of MSAs. We know. We're all politicians. We know how boards or associations can be taken over by any group at any time, and I have grave concerns about the MSA boards and how they will be elected and when and how they may be taken over.

Now, it's true the minister may override all of that, but isn't it just wonderful that the decisions are going to then be reverted to Queen's Park. Where are the improvements that are being talked about in Bill 173? Let's let the district health councils make up their own minds. Let's give some flexibility to this bill. That's what the people of Ontario are asking, and neither the NDP nor this PC motion gives the flexibility that the people are asking for. Let's build on the successes. Let's build on the bridges that are being built out there quite naturally without any help from us.

**The Vice-Chair:** That was three and a half minutes.

**Mr Jim Wilson:** In response to Mr Malkowski's challenge, I'm pleased to respond that there is nothing in the PC motion that would prohibit members of the senior citizens' consumer alliance from being appointed by the minister as consumer reps on the federated boards. There's just nothing in that motion that would prevent that. I would remind members that the minister today appoints the consumer reps to the local DHCs on the recommendations of the local communities, which is exactly what this model is. So I question where his challenge comes from.

It also leaves greater flexibility here in terms of the numbers that will be set by regulation, and there is nothing to prevent the government of the day from saying that one third of the reps on the federated boards will be composed of consumers. So I don't know where he finds his fault with this and I suggest that a proper reading of this actually gives the flexibility that he's requesting.

**The Vice-Chair:** That completes the list of speakers. The PC motion regarding part VI of the bill, all in favour of the motion?

**Mr Jim Wilson:** A recorded vote.

**The Vice-Chair:** A recorded vote. All in favour?

**Ayes**

Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Caplan, Carter, Malkowski, Martin, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sullivan, Wessenger.

**The Vice-Chair:** Motion lost.

Government motion regarding subsections 11(1), (1.1) and (1.2), the parliamentary assistant.

**Mr Wessenger:** I move that subsection 11(1) of the bill be struck out and the following substituted:

"Designation of multiservice agency

"11(1) The minister may designate an approved agency as a multiservice agency for,

"(a) all persons in a specified geographic area who require community services; or

"(b) those persons in a specified geographic area who require community services and who can be identified by,

"(i) their membership in a specified ethnic, cultural, religious or linguistic group, or

"(ii) any other prescribed characteristic or prescribed combination of characteristics.

"Multiple designations in one area

"(1.1) The minister may designate more than one multiservice agency for the same geographic area or part of a geographic area.

"Changes

"(1.2) The minister may from time to time change the geographic area for which a multiservice agency is designated and the class of persons for whom a multiservice agency is designated."

This motion is to change the MSA geographic base catchment aspects to enable the designation of MSAs on the basis of membership in a specified ethnic, cultural, religious, linguistic group or other characteristics. It's really enabling to give greater flexibility to make clear that a particular MSA may have a particular designation for a geographic area with respect to these characteristics.

1640

**Mrs Sullivan:** We'll be supporting this amendment. I'd like to refer members to a motion we have placed that's somewhat similar. Our motion happened to be placed for another section of the bill, 11(4.2) and (4.3). We had some concerns with respect to culture and condition as being a requirement or a method of providing specialized services through a multiservice agency that may have to go beyond a small geographic area, but in the case of which the minister might be able to establish Ontario as a geographic area, I suggest by example, for services which might be highly intensive and based on a small population.

The additional issue that we have been, as you know, highly, highly concerned about through these hearings is with respect to the provision of services for children. I believe that clause (b)(ii) of the government's amendment would enable a separate MSA, if necessary, to be set up to meet the requirements of children. Frankly, we spent a lot of time in our caucus trying to determine whether we should leave children out of the bill, limit the bill to the over-16s and make it an adult bill, as Bill 101 is, whether we should put forward motions that would establish separate children's agencies. You will hear from us later on about the 20% rule and how we are deeply, deeply concerned that that 20% rule will preclude an MSA from purchasing the appropriate services for

children because of the current structure of existing services, such as children's treatment centres.

As you will see, under our motion we have indicated that a particular group could be identified or a particular community could be identified and that could be referenced by age, by gender, by disability, culture, race, religion or language. I believe that those issues are included in the government amendment and we believe that this amendment needs support, and then when we move on to the next section of the bill, I will read it in and then I'll withdraw it.

**Mrs O'Neill:** I wanted to ask the parliamentary assistant if the things Ms Sullivan has just brought forward, condition and/or age or demographics, could be included in (b)(ii), if that's what's envisioned.

**Mr Wessenger:** I would confirm that (b)(ii) would permit that to be included, yes; (b)(ii) would cover that situation.

**Mr Jim Wilson:** I just want to indicate our support for the motion and refer members to a similar attempt by the PC caucus to ensure that specific MSAs can be established, as this motion allows. For instance, we did have representatives speaking on behalf of those people living with AIDS indicate that perhaps that would be an appropriate type of MSA dealing specifically with those members of our population, and that's something we tried to do in a subsequent motion.

**Mrs Sullivan:** Could you tell us where that motion is?

**Mr Jim Wilson:** Sorry, are we not at 11(1.1)?

**Mrs Sullivan:** Yes, but where's your motion?

**Mr Jim Wilson:** Our motion is (5.1), which reads, "The minister may, as a term and condition of a designation, require a multiservice agency to only provide services to a group of persons specified in the designation, and may specify as a group persons who are under 16 years of age, persons who have contracted the acquired immunodeficiency syndrome or any other persons who form a group based on age, gender, disability, culture, language, religion or race."

It serves the same purpose as the government's and that's the point I'm trying to make. That's why we're supportive of the government's motion and that'll be the end of that.

**The Vice-Chair:** Any other speaker? Government motion, all in favour? Opposed? Carried.

Government motion respecting subsection 11(2).

**Mr Wessenger:** I move that subsection 11(2) of the bill be struck out and the following substituted:

"Board composition

"(2) In deciding whether to designate an approved agency as a multiservice agency, one of the factors the minister shall consider is whether the agency's board of directors meets the following criteria:

"1. At least one third of the agency's directors are persons who are receiving or who have received a community service from the agency and such persons include care givers who are receiving or who have received a community service from the agency.

"2. The agency's board of directors includes persons

experienced in the health services field and persons experienced in the social services field.

"3. The agency's board of directors reflects the diversity of the persons to be served by the agency in terms of gender, age, disability, place of residence within the geographic area for which the agency is to be designated and cultural, ethnic, linguistic and spiritual factors."

The basic purpose of this amendment is to clearly set out the minimum one-third requirement for consumer and care giver involvement. This was set out in policy statements originally, and many groups asked that it be put into the legislation to give greater security for that protection for consumer involvement.

**Mr Jim Wilson:** I'm generally supportive of this motion, other than that I wondered where Mr Malkowski in previous debate got his one third, because it certainly wasn't in the bill until now, if this amendment is passed.

The problem I have with this, and how it differs from the federated model that we've tried to pass, is that you have no provision for existing service providers at all to be on the MSA. I know that's not your model, but it's one of the things I don't like about your MSA model. These are good people providing services now, they have a wealth of experience, they're not evil, they know how to deliver those services in their communities now and you don't allow them at all to be on the new MSA boards in the way that we did, which was that existing agencies could recommend representatives.

The way I understand this is that the minister—talk about central control—has final control over the makeup of these boards, because it very clearly says that before they can get their designation as a multiservice agency, the minister has to be totally satisfied. One of the factors she has to take into consideration before allowing the designation is that she has to be totally satisfied with the makeup of that board.

You tell me, and I wish Mr Malkowski were here, in fairness, how that is more generous in terms of consumer and local representation than the model we put forward, which would have allowed communities to make their own recommendations and the minister to approve them. If anything, the two are equal. But let's not pretend that the NDP motion here or the original wording of the bill didn't have the heavy hand of the minister. Ministerial approval is clearly required here, so it's still centralized control.

1650

**Ms Carter:** Making sure it's representative.

**Mr Jim Wilson:** It's very clear that the minister, if she for some reason doesn't feel it's representative—I mean, it doesn't give any guidelines.

**Ms Carter:** But it does.

**Mr Jim Wilson:** No. The way you can very clearly read this is, okay, one third of the directors are to be consumers. Fine. There will be some representation from those experienced in health services and social services, and the agency will reflect the diversity of the community. But the final approval of the makeup of that board is the minister. There's no denying that fact.

**Mr Martin:** It's not true. It's just not true.

**Mr Jim Wilson:** Well, I don't know how that isn't true, because it says: "In deciding whether to designate an approved agency as a multiservice agency, one of the factors the minister shall consider is whether the agency's board of directors meets the following criteria," and it lists them. What if she arbitrarily thinks that it doesn't meet the criteria or doesn't like the particular representatives who are being recommended?

**Ms Carter:** It's a very viable point.

**Mr Jim Wilson:** It's still final approval. They can't get their designation unless she is satisfied. It's very clear that in order to get approval, the minister has to approve the board.

**The Vice-Chair:** The parliamentary assistant is prepared to clarify the matter rather than have the cross-discussions, questions.

**Mr Jim Wilson:** I don't think it needs clarification. It's pretty clear.

**Mr Wessinger:** I think what we have to understand is how a multiservice agency is going to be constituted. A multiservice agency will be, first of all, a non-profit corporation which will have bylaws, which will have members, which will have members electing the directors, and that will be the structure we're dealing with.

Now, the minister has certain vehicles that can be used to try to ensure that these criteria are met. One of the vehicles of course is, in first designating the agency, to look at the agency, to look at its bylaws and to look at the composition of the board to see if it meets these criteria for initial designation. The minister can also require certain provisions to be set out in the bylaws. For instance, it could be set that a certain number of persons elected as directors have to meet the following criteria to be eligible for those positions. That could be certainly set out in the bylaw. The fact of a consumer representation would be quite simple to set out in a bylaw.

The other two criteria are more as guidelines; they may be more difficult to set out specifically. I think the consumer one you could set out specifically in a bylaw. The other two would have to be more general criteria.

But to answer Mr Wilson's question, since this is an elected board, you could have a situation where service providers are elected. They could decide to elect people who are members of service providers to the board. The general membership could decide to do that. They could decide to elect employees of service providers. They could decide to elect members of the general public. It will really be the membership of the board itself which will determine who sits on the board level. It's the same as we have with the public hospital situation. We have the hospital boards that are generally chosen by their membership, and most hospital boards in smaller communities have generally open memberships.

I would assume the MSAs will also have an open membership situation. I don't know whether we have the power to prescribe, but I believe we will have the power to make certain prescriptions about bylaws and structure through the regulation-making power of this act. So that's the way it will be envisaged. There's no guarantee there will be a service provider on there, but there's no prohibi-

tion on a service provider being on the board. It will be purely up to the way the bylaws are structured and the wishes of the membership expressed at annual meetings when they elect their board.

**Mr Jim Wilson:** I'm aware that there is a policy document circulating which specifically precludes service providers from serving on these MSA boards. If you want to have that valuable experience that's been built up over a century in our communities to be part of this MSA mix, you must provide a clause here that allows them a guaranteed space on the board, as you're doing for consumers and as you're doing for people from diverse groups. All your talk in the world about "They may be elected" is wonderful, but you've not specifically guaranteed them a spot and you've circulated policy documents that in fact show your true hand with respect to this motion.

**Mr Wessinger:** Well—

**Mr Jim Wilson:** Secondly, and I wish Mr Malkowski was here—just hold on a minute, Mr Wessinger, please—again, this motion doesn't specifically say that Jane Leitch's group, Senior Citizens' Consumer Alliance for Long-Term Care Reform, is to be on these boards. It's no different than the PC motion that he so forcefully argued against in that sense, and I want that point for the public record. He tried to leave the impression with the public that somehow there's an amendment in here by the government or something in the bill that specifically guarantees that members of that organization which he mentioned so frequently would be on these boards. That is simply not the case and I don't want that false impression left out there.

Could you please respond to me why you've got policy documents specifically targeted at ensuring that members of the existing service provider agencies shall not serve on this board?

**Mr Wessinger:** I don't know where that comes from, because if you look at the bill, it says the criterion is, "The agency's board of directors includes persons experienced in the health services field"—persons experienced in the health services field obviously have had to work for someone providing a health service, so I don't see any clearer definition there. And "persons experienced in the social services field"—obviously someone who has to have had some experience working in the social services field. So paragraph 2 does ensure that you have that representation.

**Mrs Sullivan:** We will be supporting this amendment. We have discussed two approaches to conditions with respect to governance of agencies. One of them is the kind that's reflected in the subsequent motion, which we are not putting forward, which says that the agency board should reflect "the needs and the diversity of the community to be served." That implies that the community itself would determine the nature and characteristics of the people who would serve on the board. That's one alternative approach.

The other alternative approach is to be highly prescriptive and to indicate that there shall be a certain proportion of individuals who would serve representing specific capacities, and presumably those people would bring to

the table the interests of the class of individuals whom they are specifically representing.

Our draft amendment was put forward because we wanted to have some discussion within our own caucus about what the appropriate approach in terms of longer-term operations would be and where the community control should be. Should the community itself determine the makeup of its board and the class and the nature of the components of the board of the agency which is being formed; or should the government, as a standard and as a goal and as a priority, set out the principles and indeed the rules with respect to the formation and the continuing formulation of the board?

You will recall under the Advocacy Act, the commission and the rules for the setup of the commission were highly prescriptive, and indeed it appears the government has backtracked on some of its own commitments under that act. It gives us a little pause when there's over-prescriptiveness in board makeup.

1700

Having had those discussions, we've decided that the best thing and the most reasonable approach is for the government to set out the rules and, within those rules, for the communities to make their decisions about who the representatives shall be who will sit on those boards.

One of the things that I have been doing is flipping through these amendments. I recall a government amendment later which says that an employee of an agency may also sit on a board, and I've been looking for the number of that. I have deep concerns about that amendment. I believe that in fact there may well be a conflict of interest. I don't know why it's buried somewhere else in the amendments rather than being included in this section. Before we vote on this section—I know it's a peculiar way of doing things—I wonder if the parliamentary assistant could speak to that particular amendment. I'm sorry, I just can't find it at this point in time.

**Mr Wessinger:** Yes, I can have legal counsel explain why it's not in this section. It is of course purely enabling, not prescriptive.

**Ms Czukar:** I believe it's section 17 that you're looking at. The current bill, in the rules governing approved agencies, specifies that, "In the case of an approved agency that is a corporation..., no employee of the agency may be a director...." The government is simply recommending that you vote against that section so that this rule is not there. All it means is that it's then up to the corporation to decide how it's going to set up this board and there's no rule in our legislation against that.

**Mrs O'Neill:** I just wanted to ask a couple of questions of the parliamentary assistant. First of all, this afternoon we've spent our time almost exclusively on talking about consumers and consumer participation. We're talking about people who are receiving community services. We're talking about long-term care in this bill.

I think anybody who has any experience—some of us have personal experience—knows that most of the people who are receiving long-term care are frail, elderly, disabled, so they are not going to be coming to meetings and likely not even joining MSAs, for the most part.

That's why this bill is here. So I'm very happy that the words "care givers" are in paragraph 1 as well, and we certainly had representation to that effect.

I'm having a little bit of trouble reading that particular part of paragraph 1, "and such persons include care givers who are receiving or who have received a community service...." because I would think it should be "care givers who are caring for someone who is receiving...." because the care giver usually isn't receiving the service. Maybe there is a problem or maybe I am not seeing it correctly, but I think we should be very clear here that often the care givers are the ones who are going to be representing those people who are receiving the services.

**Mr Wessinger:** Perhaps I could just explain that a care giver would receive—for instance, if they receive respite care, they'd be then receiving a service, because the respite care would be a service to the care giver rather than a service to the—

**Mrs O'Neill:** Usually "respite care" refers to the person who is getting the care; the person is not really getting care, they're getting respite.

**Mr Wessinger:** That's right, they're getting a service, respite service to the care giver.

**Mrs O'Neill:** Anyway, is this going to be clear enough for the people out there administering this, that the care givers themselves will not have to have received a service?

**Mr Wessinger:** That is correct, they will not have to have received a service.

**Mrs O'Neill:** Is that what this says?

**Mr Wessinger:** That's right.

**Mrs O'Neill:** Could you explain how it says that? I'm sorry; I'm having a lot of trouble with this because it's not clear to me.

**Mr Wessinger:** I'll ask legal counsel. Maybe they can explain it a little more clearly than I can.

**Ms Czukar:** The formulation was put this way because we wanted to ensure that we were including family care givers or people who are care givers by virtue of their relationship to the person and not including staff of the agency, essentially. Other kinds of formulations that would have said "care givers of persons receiving services" would have brought in that problem.

This is stated in such a way, we think, as to include care givers who are receiving services directly or indirectly, so that any time someone in the home is getting a service, the person is directly receiving the service, the care giver is getting a benefit from that, is getting a service from the agency, because the service that the person's receiving is relieving the care giver of doing that. This formulation was intended to clarify it that way without bringing in the other problem.

**Mrs O'Neill:** You don't want to add "directly or indirectly"? You had to explain it to us, those of us who've been working on this now for six months, every day. I think I understand this issue, but I think it has to be clarified.

If you're going to disseminate this to every MSA in

the province and they're going to interpret it, I really think it should be clear.

**Ms Czukar:** I'd have to ask legislative counsel whether she thinks that would accomplish what we're trying to achieve here.

**Ms Joanne Gottheil:** I think you could add the words "directly or indirectly" to achieve that purpose.

**Mrs O'Neill:** Then that would help me, and I hope other people, to know who this is referring to.

**The Vice-Chair:** Are you moving that?

**Mrs O'Neill:** I would hope the government would include the words.

**Mr Wessenger:** Can legislative counsel do that?

**Ms Gottheil:** It should say, "who are receiving or who have received, directly or indirectly, a community service."

**Mrs O'Neill:** I think that's helpful.

**The Vice-Chair:** After the word "received." Is someone moving that amendment?

**Mrs Sullivan:** I think the government should.

**Mr Wessenger:** Yes, we will, we'll incorporate that.

**The Vice-Chair:** Thank you very much. Does that complete your comments, Ms O'Neill?

**Mrs O'Neill:** Thank you.

**The Vice-Chair:** It's after 5 o'clock. We have three additional speakers, and then we proceed to a vote. Do you wish to proceed?

**Mrs O'Neill:** Let's go with the three speakers.

**Mr O'Connor:** I don't want to belabour this at all. I just want to say I'm in support. I think it includes more effectively the family care giver position that was presented to us by the Alzheimer Association of Ontario. I think it's better that the one-third policy is put straight up and put right in the legislation. Myself, I'd be comfortable with it if it were 50%, but given that there was a decision made, caucusing around, and that we're at a third, I'll appreciate that and go with that level. I will be supporting this government motion.

**Mr Jim Wilson:** It's clear we're at a point here in our deliberations where, the government and the Liberal Party having rejected the federated model, I find myself at this point in the mode of being stuck with most of the government's MSA model still intact and therefore am obliged to try and make the government's MSA model as palatable as possible to the people of this province.

I think it was Doug Jackson from the long-term care division, his memo on governance—remember the infamous memo presented to our committee?—that certainly suggested that directors of current service provider agencies in our communities should not be involved on the board, become directors of the MSA. I think Ms Sullivan's going to find that in our archives.

1710

I want to ask the parliamentary assistant, and it's a very important question, just to clarify this whole area for the public record, to be sure there is nothing in this legislation that would prevent, by example, a current director of the VON from serving on a multiservice

board. With your deletion of section 17—and I agree with that deletion—if we vote to delete section 17, there would be nothing in the bill to prevent a director of a current service provider agency from serving on the MSA board?

**Mr Wessenger:** There's nothing to prevent the current director from serving on the MSA board.

**Mr Jim Wilson:** Okay, I appreciate that.

How big are these MSA boards? Has anybody got any typical example? You tell us you've got some pretty well ready to go in the province. What would be some of the numbers we're dealing with, including the one-third consumers?

**Mr Wessenger:** It's obviously going to be the decision of the local planning body as to what the structure will be with respect to the number of board members. When I did hearings, for instance, under the Public Hospitals Act, it was suggested—

**Mr Jim Wilson:** You don't really want to bring those hearings up, do you?

**Mr Wessenger:** No, no, I don't, but I did learn quite a bit. I must say I learned a great deal from those hearings about how the hospital system works and about boards and governance, particularly about governance. I was hit by how important voluntary non-profit corporations were in governing the health system, and that was made very clear to me.

The suggestion was made that board size should be not much larger than 20; that was sort of the suggestion. I assume the planning body will probably try to recommend something not in excess of 20 members.

**Mr Jim Wilson:** You've answered that there's nothing preventing a director of a current agency, such as the VON, from serving on a local MSA. The final question is, are you inclined at all to make a special provision, though, as you've done for consumers and others, to ensure that there is a guaranteed space on the board for a representative of a current service provider agency to become part of the MSA, which is in the PC amendment to clause 11(2)(c)?

**Mr Wessenger:** We don't think it would be appropriate to prescribe that, but the long-term care committees establishing these MSAs—if you have a transition stage, you're obviously going to have the main providers sitting on the board membership. I would think it would be obvious that any planning body would try to work on that matter, because if you're going through a transition stage when you're having purchase of services outside the MSA model, you'd want to have that—

**Mr Jim Wilson:** I asked that because you go out of your way, in your new amendments on job security, to wipe out any job security for senior executives of existing service provider agencies. You have a clause that says this section does not apply to senior executives. So you certainly go out of your way to make sure they won't have jobs, and I don't really trust you to not try and do something in your policy guidelines to make sure they don't sit on the board also. You certainly in legislation, later on in your own amendments, make sure they won't have a job. That's sad, that people, just because they're

in management, are not given any type of job protection and yet you're going to be extending job protection to other employees.

**Mr Wessenger:** There's certainly nothing that would prohibit or discourage the participation at the board level of persons in their position with respect to the service provider.

**Mr Jim Wilson:** So you can assure me that Doug Jackson or other people in the long-term care division won't be sending out any more memos about governance that say these people should not be encouraged to be on boards—or whatever the language is, and I'd be happy to find the language.

**Mr Wessenger:** I think the legislation has to prevail over, shall we say, suggestions.

**Mr Jim Wilson:** I know, but you know what suggestions are like. When they come on government stationery, people take them as direction that must be followed.

**Mrs Caplan:** I thought I might share with the committee some of my own experience in the matter of encouraging consumer and family participation as opposed to professional and provider participation.

I think it's very appropriate that the minimum level of one-third of spaces on the organization be reserved, because that's what effectively this is doing, for those people who might say, "Gee, I don't have any experience in the delivery of services," or "I'm not an expert." This is often what you hear from people who are reluctant to come forward and participate.

These people are usually those who have received service or might receive service in the future and have an interest in the subject but don't have the confidence, because they think in order to be on an agency or a board they have to have experience and expertise. From my experience, if there is a prescription, a reservation for individuals without experience, without professional education and professional designation, they're far more comfortable to come forward and take the opportunity offered to them.

I want to say I support the amendment, because unless that signal is given, I think the consumer or the caregiver of the client is often too reluctant to come forward. I'm pleased to see an amendment that reserves a minimum number.

I understand the discussion around, "Then why don't you reserve for the provider?" but the reality is that providers know how important it is for them to participate, and, because it is frequently part of their job descriptions and time is made available by their employers, they are able to participate in this kind of very important community service, and it is community service. The other two thirds, more likely, in the situations will be easier to find. As you pointed out, it could be more than one third of consumers who ultimately are chosen, but you've

reserved at least one third of the spaces to encourage those people who might be insecure or reluctant because of their lack of experience in serving on boards. From that aspect, this is a good amendment.

I do have a position I'd like to put forward for consideration by the government in light of the amendment that's coming in the future. As a matter of general principle, I believe, and I think others as well believe, that employees have an inherent conflict and therefore, rather than serving as voting members of boards, can be on those boards as non-voting or what's frequently called ex officio members. I think it is appropriate for them to be there as non-voting ex officio members, and I'd like the government to consider that status to allow employees to feel they have full access to the board, full ability to participate, but when it comes to voting that it is inappropriate for an employee, whose interests may be other than the interests of the clients or of those receiving the service.

I want to offer that as a suggestion to the government rather than simply deleting the clause now and then just sending the signal that employees could well be members of the boards. It's something I feel is in the public interest, to make that distinction between voting and non-voting board members. Rather than getting prescriptive in how many and so on and so forth, that can be decided locally, and you'll have differences in different organizations as it goes forward.

That was the comment I wanted to make on the structure of the boards. I will be supporting this amendment for the reasons I put forward.

**The Vice-Chair:** The government motion regarding subsection 11(2): All in favour of the motion? Opposed? Carried.

Because of the hour, we face adjournment. Before that, one question: When does the committee wish to meet again on this bill?

**Mr O'Connor:** Given that this committee sits on Mondays when the House is in session and that the House resumes on Monday, hopefully we can meet on Monday. If necessary, the subcommittee could try to converse before that.

**The Vice-Chair:** You're suggesting Monday afternoon.

**Mr O'Connor:** When we get to routine proceedings on Monday.

**Mr Wessenger:** Yes, that we continue on Monday.

**The Vice-Chair:** And Tuesday as well, then; we'd meet Monday and Tuesday.

**Mr Wessenger:** Tuesday as well.

**The Vice-Chair:** Thank you. The committee will now adjourn until Monday afternoon next.

*The committee adjourned at 1719.*



## CONTENTS

Thursday 27 October 1994

**Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,**  
projet de loi 173, M<sup>me</sup> Grier ..... S-2449

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair /Vice-Président:** Eddy, Ron (Brant-Haldimand L)

**\*Carter, Jenny** (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

**\*Martin, Tony** (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Caplan, Elinor (Oriole L) for Mr McGuinty

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

Malkowski, Gary (York East/-Est ND) for Mr Hope

Sullivan, Barbara (Halton Centre L) for Mr Beer

Wessinger, Paul (Simcoe Centre ND) for Mr Owens

#### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Czukur, Gail, counsel, legal services branch

Quirt, Geoff, acting executive director, long-term care division

Wessinger, Paul, parliamentary assistant to the minister

**Clerk / Greffier:** Arnott, Doug

**Clerk pro tem / Greffière par intérim:** Bryce, Donna

**Staff / Personnel:** Gottheil, Joanne, legislative counsel



## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 31 October 1994

# Journal des débats (Hansard)

Lundi 31 octobre 1994

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

Long-Term Care Act, 1994

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 31 October 1994

Lundi 31 octobre 1994

*The committee met at 1557 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen. The standing committee on social development is in session and we are dealing with the clause-by-clause on Bill 173. We had last week completed dealing with the amendments up to subsection 11(2) and we are now dealing with a Liberal amendment, clause 11(2)(a). Ms Sullivan, do you want to move that?

**Mrs Barbara Sullivan (Halton Centre):** Mr Chair, as a result of the government motion, I had indicated that I'm not going to be putting this amendment forward. However, I do have an amendment to subsection 11(3.1).

**The Chair:** There are a number of amendments before that, so I just need to know that you are withdrawing.

**Mrs Sullivan:** I haven't put it forward.

**The Chair:** So it's not moved. We will then go to a Progressive Conservative amendment, Mr Wilson, if you would be good enough to move the next motion, which is clause 11(2)(b).

**Mr Jim Wilson (Simcoe West):** Mr Chairman, I won't be introducing this amendment.

**The Chair:** All right, not moved. The next one on my list is another Liberal amendment, clause 11(2)(c). I might just note, that was a first nations amendment, and I believe there was an understanding that would be stood down and dealt with collectively.

**Mrs Sullivan:** That's right. We're standing those ones down.

**The Chair:** That's clause 11(2)(c). We move then to Progressive Conservative motion 11(2)(c).

**Mr Jim Wilson:** I will move this one, Mr Chairman, and just feel the government out on this particular issue.

I move that subsection 11(2) of the bill be amended by adding the following clause:

"(c) includes persons appointed to the board by the health and social service agencies who are partners with the community in the multiservice agency."

By way of explanation, since the government and the official opposition voted against our federated model, which would have ensured that members of existing service agencies in their communities would be repre-

sented on the multiservice agency board, this amendment is an attempt to again ensure that those people who are currently supposed to be, in the government's old language, "partners" in the community now, partners with the government—some of these agencies, as you know, have been delivering care for at least 75 years in the province—are allowed to serve on the multiservice agencies.

The government has gone out of its way in 11(3) to put in a bias against boards of health and municipalities, and following on a policy document that was circulated by the ministry itself, I still am suspicious that the hidden agenda here is to ensure that current service providers are not allowed on the MSA. Now, the government denies that, but if it wants to ensure that these people are allowed on the MSA and that they're included as part of this partnership arrangement, it should accept, and I'd urge it to accept, this particular amendment.

**Mr Paul Wessinger (Simcoe Centre):** We will not be supporting this motion because it's really supportive of the federated, appointed model of directors of an MSA, and we are supportive of course of the elected, community-controlled model.

**Mrs Sullivan:** With a slight amendment to this motion, rather than "includes persons" to say "may include persons," we could support it. As you know, we believe each community should be able to determine the shape of the organization that will deliver the services within that community, those services being identical across the province and the quality of those services being identical across the province. If I may, I would put a motion to amend the PC motion.

**The Chair:** I wonder if that is seen as a friendly amendment.

**Mrs Sullivan:** Would that be seen as a friendly amendment?

**Mr Jim Wilson:** Yes. Anything to try to get something in this bill.

**The Chair:** Ms Sullivan, do you want move that? We need to deal with your amendment and then to deal with Mr Wilson's.

**Mrs Sullivan:** I would move that the word "includes" be struck out in the first line and replaced with the words "may include."

**The Chair:** All those in favour of Ms Sullivan's amendment to the amendment?

**Ms Evelyn Gigantes (Ottawa Centre):** Are we going to have a discussion of it?

**The Chair:** If you wish.

**Mr Wessenger:** I will certainly not be supporting the amendment because it still leaves the aspect of members being appointed to the board. It's contrary to the elected board model. That's the reason—even the amendment.

**The Chair:** Any further discussion? Okay, all those in favour of the amendment? All those opposed? The amendment is defeated.

We then move to Mr Wilson's amendment.

**Mr Jim Wilson:** A recorded vote, Mr Chairman.

**The Chair:** A recorded vote. All those in favour?

**Ayes**

Wilson (Simcoe West).

**The Chair:** All those opposed?

**Nays**

Carter, Gigantes, Malkowski, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sullivan, Wessenger.

**The Chair:** The motion is lost.

The next motion is a government motion.

**Mr Wessenger:** I move that section 11 of the bill be amended by adding the following subsection:

“Charitable objects

“(2.1) In deciding whether to designate an approved agency as a multiservice agency, another factor the minister shall consider is whether the agency has objects of a charitable nature.”

This adds another factor for the minister to consider when deciding whether to designate an approved agency as a multiservice agency. Certainly in the presentations there was a request that MSAs should have charitable status, so this adds charitable status to the list of the factors the minister must consider when deciding whether to designate an MSA.

**Mrs Sullivan:** We will not be supporting this amendment, and I think the reasons are clear. I hope the government will reconsider this amendment. When one looks at the definition of “agency” in section 2 of the bill, “agency” would mean a corporation without share capital which is incorporated under the Corporations Act in Ontario and that's carried on without the purpose of gain. It may also mean a corporation, under clause (b), “that is carried on without the purpose of gain for its members,

“(c) a municipality,

“(d) a board of health, or

“(e) a council of a band,” which is defined under the federal Indian Act.

By incorporating this amendment into the bill, the government is saying that a municipality, a board of health or a council of a band cannot become a multiservice agency, and I'm asking the government to vote against its own amendment.

**Mr Wessenger:** If I might respond, this is an enabling factor, it isn't a mandatory factor that an MSA must be charitable. It's one of the factors the minister looks into in the question of whether to designate. It doesn't force every MSA to have charitable objects.

**Mrs Sullivan:** I believe the factors which apply in this area are included in the definition of the word “agency.” We, as you know, had wanted to include an incorporation status so that the Red Cross could be included as an agency which could become an approved agency and hence, latterly, a multiservice agency. However, the government voted that down.

I believe this is a redundant motion and that its inclusion provides an indication that there is a preference to an organization that is not either a municipality, a board of health or a council of a band. Particularly in the case of first nations it is a most inappropriate assumption, and I believe the government should vote against its own motion.

**Mr Jim Wilson:** I really have a question about this particular motion put forward by the government in terms of the wording “shall consider...whether the agency has objects of a charitable nature.” To me, that doesn't necessarily require the agency to have charitable status, as implied in Mr Wessenger's comments.

A number of groups are extremely worried that when the MSA takes over the services they're now providing, volunteer dollars and fund-raising dollars will be lost. I know this is an attempt by the government to make sure tax receipts can be issued by the MSA and have a charitable status, but to me this amendment doesn't go far enough in that respect. It doesn't require them to have a charitable status, it just says they'll have objects of a charitable nature. Perhaps it's the legalese that I'm not familiar with, and I'll give Mr Wessenger an opportunity to comment on that.

**Mr Wessenger:** You're quite right in that the intention is to encourage MSAs to be in a position to issue receipts for charitable donations. It certainly is the preference to have MSAs of that, but there undoubtedly will be some MSAs that may not, for various reasons.

For instance, assuming we come to a first nations definition, that would not be deemed to be a charitable organization with charitable objects, so obviously in that instance you'd have one situation where you wouldn't have charitable objects. Boards of health have indicated, for instance, that they could probably work around the aspect of having charitable objects. A municipality could not.

I know donations to provincial and federal governments are tax deductible, but I'm not certain of the status of a donation to a municipality, whether that would get you a tax credit or not. Unfortunately, legal counsel is not in a position to answer that question either. But the intention basically is to encourage the tax deductibility of donations to multiservice agencies because it will enable them to fund-raise, which would certainly be very important to their role in the community.

1610

**Mr Jim Wilson:** The uncertainty you leave with the wording of your motion, to me makes the motion useless. I mean, whoopee ding-dong: You're saying they should be of a charitable nature. You're either saying you want them to have charitable status and therefore people who currently donate to the Red Cross or VON or Saint

Elizabeth's or all our other denominational agencies will get a tax receipt—perhaps then you may want to consider the wording of your motion.

If exceptions to this rule are to be made for municipalities—and I too don't know the ruling on municipalities right now—we certainly don't want to see anything in this bill that has a bias against municipalities and boards of health. That's why we'll be calling on members to delete 11(3), which contains that bias. But I think you can clean up the wording in this section to provide for an exception for municipalities if that's required, or first nations, and ensure the charitable status. Otherwise, the argument the current agencies are making about losing millions of dollars in volunteer money is a very valid argument, given that you're admitting, by this attempt by way of motion, that your current bill certainly doesn't require charitable status, and this motion is not a suitable remedy for what you're trying to accomplish.

I'd ask you to think about this before we vote and ask legal counsel again if there isn't another way to do this. I think we have to ensure that MSAs—even though I'm opposed to all you're doing, we're getting stuck with it—are able to issue tax receipts; otherwise there will be a considerable loss of charitable dollars to the system, and government cannot afford to lose any dollars to the system that are currently coming by way of volunteers or through the good-natured people in our communities and service clubs and so on who are donating to these agencies now.

**Mrs Sullivan:** I'm going to ask the government to either stand this motion down or withdraw it. I believe it's indicative of sloppy thinking and sloppy drafting. The definition of "agency" includes the fact that corporations that are carried on without the purpose of gain are there, that municipalities, boards of health and councils of bands are included. They are, by definition, organizations that are carried on without the purpose of gain. This wording (a) is inadequate, (b) is confusing and (c) adds nothing to the bill.

**Mr Larry O'Connor (Durham-York):** I support this motion. I think one of the important things we understand is that this is a consideration being placed before the minister before a decision is made. We heard, for example, the concern around one third consumers being left to a policy decision, and I thought it could have been higher, while putting it in the legislation—what we're doing in this case is putting it in the legislation that part of what is going to be considered is the charitable nature of the agency. I think it makes good sense that it be placed exactly where it is.

**Mrs Sullivan:** It's included in the definition already.

**Mr O'Connor:** I can see where maybe my colleagues have some concern, and maybe some of those other areas we're going to have to look at later, but not in this sense right now.

**The Chair:** Final comment, parliamentary assistant, and then I'll call the question.

**Mr Wessenger:** I think it should be made clear that this amendment doesn't make mandatory; it's enabling. However, I think it has a definite positive impact,

showing there's a positive aspect for an agency to have charitable objects when the minister is considering it.

I think that indicates it's a favourable factor to consider when the minister is looking at alternative models and also some direction to the local planning. In the ultimate end, it's the local planning committee of the district health council that's going to determine actually the structure. But this certainly gives a positive guidance to the long-term care committee in this area.

**The Chair:** Any further comments? I call the question. All those in favour of the government amendment? Opposed? Carried.

We then move to a Progressive Conservative amendment, Mr Wilson, to 11(3).

**Mr Jim Wilson:** It'll probably be ruled out of order, but I move that subsection 11(3) of the bill be struck out. I think the note in here probably should read that the PC caucus recommends that we vote against—

**The Chair:** Mr Wilson, it is in order.

**Mr Jim Wilson:** It is in order?

**The Chair:** Yes, your motion is in order.

**Mr Jim Wilson:** Thanks. Then I move that subsection 11(3) of the bill be struck out.

You used to have to vote against sections.

**The Chair:** Would you like to address your in-order motion?

**Mr Jim Wilson:** I appreciate that it is in order and I want to bring to the attention of members the various groups that asked that this section simply not exist in the bill. The section, for people who are watching this, is the section that creates a bias against boards of health and municipalities from becoming approved agencies and MSAs.

The point is, we don't see any reason for this. In fact, in existing communities where boards of health are very much now part of the service delivery system, they should be at least given equal opportunity to become the multiservice agency in that area. I know that a number of boards asked for that; a great many municipalities asked for this section to be deleted because it doesn't make any sense the way the bill is drafted. Boards of health and municipalities become sort of the MSAs of last resort. We just think it's fundamentally unfair that the government has put this in the bill.

I'll tell you that groups like the Middlesex-London Health Unit, the Ontario Home Care Programs Association, the Ontario Community Support Association, the Hamilton branches in particular, plus the support association representing the whole province, made this presentation. CUPE, the Municipality of Metropolitan Toronto, homes for the aged division, Health Care Unions of Ottawa-Carleton, Peterborough County-City District Health Unit, Ontario Association of Non-Profit Homes and Services for Seniors made this recommendation.

As well, I've had representation from Mr Mike Harris's area of the province, and I know my colleagues Mr Bob Runciman and Mr Dave Tilson also made very strong representation in our caucus on behalf of their municipalities, and so did other caucus members, to

ensure that we delete this section of the bill. If there's something the government can do this afternoon that's helpful, this is one of those areas. It won't hurt you, it is helpful and I think you should support it.

**The Chair:** Just for your own information, if you had been moving simply to delete the whole section, it would have been out of order. But because it's—

**Mr Jim Wilson:** Oh, I'm sorry. You can't delete a section.

**The Chair:** Yes. Discussion on this motion?

**Mrs Sullivan:** We will be supporting this amendment and have an amendment to put forward latterly that has a similar effect. We feel that in many communities where the board of health or the municipality has been delivering services and where that continuation is the choice of the community when the delivery mechanisms are being designed, the municipality or the board of health should receive the consideration of being designated an agency or a multiservice agency on the same basis as any other agency that the local community would recommend. The amendments that we have provided later on would ensure that the restrictions with respect to the board membership and the makeup of the board would be altered as a result of bylaw changes.

We feel that the ministry is creating a hierarchy that's based on a stubborn adherence to one value that's being put forward. As we've said before, for some communities that may be the appropriate model; for many other communities it will not be the appropriate model. We believe that flexibility to ensure that the system is designed according to the priorities of the local community must be given preference and we will be supporting this amendment.

1620

**Mr Wessenger:** We will not be supporting this amendment. We believe the purpose of the section is to ensure that other choices are looked at first before boards of health or municipalities are considered.

**Mr Jim Wilson:** Sorry. I missed that comment.

**Mr Wessenger:** The purpose of the section is to ensure that the long-term care committees look at other choices before looking at boards of health before making a recommendation.

**Mr Jim Wilson:** That's very nice. We've been told that all the way through committee, but why?

**Mrs Sullivan:** There's no logic to that.

**Mr Jim Wilson:** Give me a why before you ask us to vote on something.

**The Chair:** I think the parliamentary assistant has responded—

**Mr Cameron Jackson (Burlington South):** To the best of his ability.

**The Chair:** —and we'll have to deal with that response. Mr Jackson, did you have anything?

**Mr Jackson:** Can't argue with that. Just briefly, I wanted to bring to the attention of members and remind them of the very strong presentation from AMO and from the various health service agencies that are currently municipally based and that were very concerned about

this section. I'll briefly refer to the AMO summary paper, which says:

"AMO has continually called on the province to work with the municipal sector to determine the appropriate local authority model for health and social services in their communities. Our association strongly believes that municipalities should ultimately make the decision in the local authority for health and social services. However, AMO believes that this can only occur if the province recognizes the values of the municipal role and agrees that the municipal option should be the first option....municipalities must share in the decision-making process on the issues which impact on their future role in the system."

As I said earlier this afternoon in the Legislature, what we're asking for in this clause is to give some sign of good faith on the part of the government that it's even considering options which are locally determined and locally based with all the major current and future providers of services to seniors.

Frankly, specifically for the government to determine that this whole group of people should be eliminated from the equation and not participate when in fact they're currently providing various levels of services is an inappropriate judgement. Therefore, this clause which we're asking to have deleted frees the hand of the legislation for it to be more flexible. Again, there are places in this province where the municipal support services could form a vital link within an MSA and could provide it.

Where it surfaces in my mind very significantly is where we've already invested millions of dollars of taxpayers' money into facilities, equipment and so on. There may be some logical MSAs that are built around those services already paid for by taxpayers. What we're fearful of is that those moneys will now be spent, in fact wasted, as we move to some other creation of a brand-new agency when we have these existing structures to work within.

I'd rather see those moneys spent on direct care and not put into buying and leasing office space when that office space exists because that municipality's already paid for it and constructed it and so on.

AMO makes a strong argument, I think. The government was wrong to have frozen them out of the consultation process, to not have consulted with them, and now at least it could respond in a positive way with this amendment, not to change this legislation dramatically but to allow for the flexibility and not bind the hands of a future Minister of Health with respect to being open-minded about which agencies might present themselves to be eligible to become an MSA.

**Mr O'Connor:** I appreciate the rationale as my colleagues try to convince us and, I guess, those watching that the presentations made to us said that they supported this elimination, for example, of the position by CUPE and the OFL.

In fact what they said to us when we went through the consultation and the hearings was that if a board of health, if the local unit, the municipality, was to be part

of this, then it would have to be subject to the very same conditions. The condition, of course, that is fundamental to this reform is the empowerment of the consumers, of the communities, so that the MSA is going to be reflective of the needs of the community, and the board would be made up that way.

The problem we have is that a municipality, the board of health, isn't made up the same way. So yes, we heard some presentations being made saying, "We agree with that, if they are subject to the same conditions that every MSA is going to be subject to." The problem is that they can't be. If we were to take a look at trying to allow the consumers the right to participate, how would they participate in, as my colleagues put it, a federated model for a huge one, for example, that we would face right here within Toronto?

I think that sometimes we can miss the point the presenters have made to us. The fact of the matter is that if this was to be removed, then, to allow them to be the first line of choice—I think that's what we're hearing from the opposition. They don't want to have the consumers being involved in the decision-making locally right from the very beginning. For them to move to say that the board of health—

**Mrs Sullivan:** Oh, that's baloney. Look at the voting record.

**The Chair:** Order, Ms Sullivan.

**Mr O'Connor:** —is the most responsive and that these municipalities are reflecting the consumers that they want to serve—

**Mrs Sullivan:** Misleading the people of Ontario, that's what you're doing.

**Mr O'Connor:** —I find that rather a ridiculous statement for them to be trying to support. Anyway, I certainly wouldn't support this PC motion before us.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I think there has been some selective listening going on around here.

**Mrs Sullivan:** Boy, you're not kidding.

**Mrs O'Neill:** Certainly if we remember the hearings in Ottawa, this was a very big item in Ottawa because in most of the municipalities in eastern Ontario, the local government is a very major player in long-term care.

Every member of this committee got a letter from Renfrew. In Renfrew they are the providers. On that day this particular document was handed out in Ottawa: Governance of Multiservice Agencies. They could see not one single area where there was a role for them, and they were most disturbed.

I don't know where the last speaker, Mr O'Connor, feels the municipalities and those who govern them come from. They are elected by consumers. They're accountable to consumers. They've got to go back to them every three years. In fact they're in the midst of that right now, as we all know.

So where this group of people who are suddenly going to now be heard who never have been heard before are going to come forth in the MSA really blows my mind. Every single agency in this province has a governance structure, and they're not all providers. There are a lot of

other people on those boards who are not there because they're providers. They're there because they're interested, they're there because they've had experiences, they're there because they're interested in their communities. They are consumers, they are concerned citizens.

This is nothing new. You haven't reinvented the wheel. Really, I'm kind of tired of hearing that for now and forever, something new is going to happen, a new group of people, a much more intelligent, in-touch group of people are going to be in charge of long-term care. It's just not going to happen, folks.

1630

**The Chair:** Mr Wilson, a final comment on your motion.

**Mr Jim Wilson:** It may not be the final comment. This is a pretty important clause. I don't recall anybody putting us under orders to wind this thing up. I think Mrs O'Neill was quite right in saying she didn't know who the government was listening to. They've done selective listening, because I listed the groups in my previous remarks, major players in the system now that wanted this amendment, and you didn't answer my question on why the bias against. On the concerns you have and the government's belief, it appears, that municipalities aren't somehow accountable, as Mrs O'Neill described, you don't have a more accountable system in our democracy than elected officials.

I know you want to have consumers on these boards. Then, rather than the way you've gone about drafting this legislation and having it biased against municipalities and boards of health, why aren't you putting in a clause that would adjust the makeup of boards of health to have some consumer representation with respect to long-term care services? That would be the more positive way to go about this and certainly would address your concerns.

I find it offensive, on behalf of elected representatives of this province. Because you people aren't representative of the people of Ontario, it doesn't mean you should cast the same aspersion over municipal councillors; they're darned representative.

I'll tell you the real reason behind this legislation—it's no wonder we get our blood pressure up around here—it's because you know, and we were told by municipalities, that they wouldn't put up with this crap, and you'd have a heck of a time doing your social engineering. I can tell you that the good people on Simcoe county council that serve on our Simcoe county board of health wouldn't put up with this. They would not allow the 80-20 rule. They believe that the current players in the system should continue to exist. They will help them coordinate, as they're doing right now through our board of health and through our county government. You just can't get your way.

They wouldn't let you do the one-stop unionization because, yes, they are very responsible. Same thing: They won't implement your welfare changes, and they didn't implement the 10% rule when you tried to bring that in, because there are a lot of people out there who have a heck of a lot more common sense than this government is prepared to demonstrate. They just won't do your

bidding. That's why you've got to get them out of the system. That's why they've become MSAs of last resort. You have no logical arguments. You can't even answer the question right now of why you want to do this.

So if they were included in your legislation, they wouldn't do your bidding. I strongly believe that that's what's behind your bias, not this politically correct stuff about, "They're not representative at all." That's just bunk. They're more representative of the people of Ontario than you people are.

**Ms Gigantes:** I'm going to be very brief. I think the issue that we're debating here is an issue about how we see the delivery mechanism for long-term care and whether we see it as a community-based organization which, having goals which are non-profit goals, incorporates people who are actually part of the consumers' group, including families of consumers, into the body which makes decisions around the coordination of service and the provision of service. That's the vision that the government has.

**Mr Jackson:** Is that the way your housing co-ops work?

**Ms Gigantes:** What the legislation says is that municipalities can be considered as organizations to function as an MSA, the multiservice agency, or boards of health may, but first there is an onus in the legislation for the people involved in the decision-making and the recommendation process to suggest to the minister whether it's possible there are other organizations and other people who can provide that service.

Members of the opposition have traipsed around Ontario—I won't be long, Mr Chair—claiming that this legislation is superbureaucratized, yet we offer legislatively to have a process through which the selection of the people to serve on the multiservice agency is opened up and it does not necessarily become a public health board which has a lot of notables at the local level on it or a municipality which has a lot of notables on it, of course, who can easily organize to have their voice heard and say that this is the organization which best serves the community.

The legislation says that there is an onus in the process to look around and see first if there is somebody else who can provide that service. To me, that seems more unbureaucratic. Perhaps I can tempt the opposition to rethink its position on this one.

**Mrs Sullivan:** I think what the government is doing is saying that groups and organizations which have a history of service delivery, whether they are municipalities or boards of health, whether they're Red Cross or VON or Saint Elizabeth, are in fact the last priority for consideration with respect to the implementation of reform of the system.

This bill enables the government to ensure all of the accountability that it requires, in terms of the basket of services, in terms of the quality standard, in terms of the health and the social services that must be provided in every location, in terms of the coordinated access to service and, indeed, the nature of the assessments that are to be carried out. The government has additional control

through the funding mechanisms. As you know from amendments which we attempted to put forward earlier, the government will not even guarantee that the mandatory basket of services is funded.

The last priorities the government is willing to consider are those groups and organizations which may well be selected by and from the community to become the place through which services are organized and delivered, through which services are coordinated, through which, in the case of a municipality or board of health, the situation may well be that there could be direct delivery.

The process has not been opened up. If the members would recognize it, this bill, under section 19, does provide a mechanism through which a representative board of a board of health can be brought together through changes in the bylaws.

That circumstance is already allowed under this act. Boards of health and municipalities are seen as a last priority, when in many communities in fact the full function of the multiservice agency is now carried out quite efficiently and quite effectively by a board of health or a municipality.

It makes absolutely no sense to dismiss what, in many communities, will be the number one choice among people who are involved in the decision-making. Frankly, if you want to talk about representative bodies, the district health councils that are making these decisions aren't awfully representative. They're unknown in most communities; they're certainly invisible in many. Because they are required by the minister to reflect the minister's wishes rather than the community's wishes, they're not reflecting what is being required and asked for by people who live in the communities, of people who want and need the services and the improvement in the coordination and access to those services.

This government, by saying that every opportunity that a local community decides ought to be put forward, ought to be put on the table, ought to be considered on the same level, can't be done—that's what government's saying in this bill. It's saying that the Red Cross can't be considered at all. It's saying that municipalities and boards of health have to be considered last, even if they're the first preference of the community.

The government is saying: "You must have another look. You must spend a whole bunch of money. You must divert money away from service and put it into this never-ending consultative search" for what is the government's model that's totally, totally unnecessary and that does not reflect the needs of particular communities, and in fact in many communities simply will not work.

**1640**

**Mr Jim Wilson:** I think not only are boards of health and municipalities being discriminated against in 11(3), which is the subject here, but members will recall with respect to 11(2) that an amendment was passed when we last met to allow at least one third of the agency's directors to be persons who are consumers.

The government shows its hand in two ways. One is that you're not prepared here today, with your previous amendment regarding charitable status, to even answer

the question of whether municipalities or boards of health—

**Mrs Sullivan:** That's right. They haven't done their homework.

**Mr Jim Wilson:** You haven't done any homework, so you have no intention whatsoever of ever designating a municipality or a board of health an MSA. Those speeches are bunk. You can't even answer the question of whether they fit into your last amendment regarding charitable status.

Secondly, you've said the agency's board must have one third consumers. A wonderful goal, we agree. But you have no amendment in here then to adjust the legislation that boards of health operate under to ensure that their boards are able to change to actually become an MSA.

I know all of these points are things the minister "shall consider." However, she has a number of things to consider, most of which are stacked against a board of health and a municipality. The fact that you can't even answer our question shows that your hidden agenda is that you have no intention whatsoever of ever designating these people, and I don't know what you're going to do. In tearing down the current system, it's just another group that you're attacking, and you can't tell us why other than this crazy—and I say it publicly as loud as I can—crazy consumer argument.

It's as if my local councillors aren't consumers and don't have families and haven't, by the way, for years served on long-term care committees in our communities and served cross-appointed to DHCs.

Many of these same elected people do so many other things in our communities. They know a lot more about long-term care than we probably know. They've run the institutional side, they've run the homes for the aged by committee through our municipalities, and they have years and years of expertise.

I think of a fellow by the name of Don Bell, who's not running this time, but I think for at least a decade in Simcoe county he has chaired finance and he has chaired the committee of county council that oversees and operates the charitable homes for the aged. His knowledge of long-term care, both on the institutional side and with respect to the community-based side, is second to none. He and the hundreds like him across the province don't get paid a lot of money to be on municipal council, and they certainly don't get a lot of money to drive up to county council or be on regional government in some parts of this province.

They're doing this because they are consumers too, because they have the same reasons why I hope all of us ran: You want to make your community a better place.

Your motion here and your intentions I think are just wrong. I mean, 11(3) singles them out and says: "We don't trust you. You're not representative." That's what they see in it, that's what they came forward to tell us, and that's exactly what they see. It's a slap in the face, your legislation, and now you won't even delete what clearly is a very offensive clause.

With respect to DHCs, I agree with much of what Mrs

Sullivan said. If the DHCs were truly representing communities, then they would have appeared before this committee and gone to bat for the Red Cross and the VON etc, because overwhelmingly that's what our communities are telling us to do, and everywhere we go in the province that's what they're telling us to do. But no, DHCs were mute on that, with the exception of one that I can think of off the top of my head. They just spoke about their section of the bill, while it really calls into question what the purpose of a DHC is, and I know we'll get to those sections later.

But I do agree with the comments that have been expressed that they're not bringing forward the concerns and wishes of their communities. They're simply fronts for the government's bidding, and that has to change in this province.

So I would ask you to reconsider this before the vote, because you're doing damage here that you don't need to do to meet your objectives. In fact, let's not pretend that you're ever going to designate a municipality or a board of health as an MSA, given that you're stacking all the cards against them, not only in the original bill but through your amendments.

**Mr Wessinger:** If I just might sum up, I think, first of all, we should be clear we're talking about preferences here and not absolutes. So I'd like to correct the impression of the impossibility for a board of health or a municipality to be an MSA. And I think if you look at the reason for these preferences, you have to look at what is trying to be achieved in the purpose of how the service is to be delivered.

First of all, what we're looking for is community-controlled organizations, for single-purpose agencies, and municipalities and boards of health do many other functions other than deliver long-term care.

Secondly, I think one has to be cognizant of the fact that in this province, for delivery of social services and health care the preferred model tends to be non-profit organizations. I think if we look at municipalities and boards of health, we're looking at a government-delivered service. I think there are difficulties with respect to boards of health and municipalities to try to incorporate the one-third consumer requirement.

In view of all those considerations, we believe it's correct to have the preference for the non-profit community "single-purpose body," and also it's important that we have a long-term care body that is not purely a medical model but also includes the social service aspects.

**Mr Jim Wilson:** Well, that's amazing. Now you want single-purpose agencies when the whole idea here was to coordinate services out there from a divergent group of agencies, and now, I don't know, they're going to be like—you know, just beyond me.

Boards of health: I haven't seen one make a profit yet, they're not allowed to, or municipalities, so I don't know where you get that argument.

What was your latter point?

**Mrs Sullivan:** The medical model.

**Mr Jim Wilson:** Oh, the medical model. Oh, my God. You clearly haven't even met with your own head

of the board of health, Dr David Butler-Jones, in Simcoe county. You couldn't have a person who espouses anything but the medical model, and Walter Ewing, his sidekick. Their whole mandate is not the medical model. It's education, it's community-based services, it's non-profit; it's exactly what you want.

**Mrs Sullivan:** It's prevention-promotion.

**Mr Jim Wilson:** Thank you. It's prevention-promotion. Go back and read the bloody legislation they run under. To say that they're promoters of the medical model is certainly contrary, in fact, the opposite; I go up and argue with David Butler-Jones sometimes about having a balanced—

**Mr Wessenger:** I didn't say that, Mr Wilson.

**Mr O'Connor:** He didn't say that.

**Mr Jim Wilson:** I thought he said one non-profit—well, they are non-profit. Single-purpose agencies: Well, this is new language that really throws me off, because what the hell's the purpose? You can't even answer why. Not only a single-purpose; they're supposed to be coordinating a whole diverse group, we're told out there now, and that, to me, would mean that they're a multidisciplinary, multipurpose, multiservice delivery model, not a single-purpose body. It's just mind-boggling, your reasoning here, Mr Wessenger, and frankly there's got to be some rule around here that we can stop you in this madness. It's just crazy, crazy, crazy. Maybe we should have mandatory assessments or something of members who are serving on this committee. I know I'm starting to lose it.

*Interjections.*

**The Chair:** Order. We're getting into treacherous ground here, members.

**Mr Jim Wilson:** Well, I mean, I'm starting to lose it, because once I get into this socialist engineering quagmire, I can't understand it. But there should be a rule, Mr Chairman, and I don't promote the logic police or something, but logic should have to prevail in these discussions. This is nuts.

Mr Wessenger, try again to convince me of this, but it's not working, and I think every time you try and tell us why this clause has to remain and why you won't delete it you get yourself further in trouble, which leads me to believe that you guys really don't know what you're doing here.

1650

**The Chair:** Before recognizing Mr Wessenger, I just wanted to say as Chair that I think we have set out a number of ideas around this clause. Clearly, there are differences of opinion, and Mr Wessenger, if there's something you wish to say—

**Mr Wessenger:** Put it to the vote.

**Mr Jim Wilson:** Recorded vote.

**The Chair:** All those in favour of Mr Wilson's amendment?

**Ayes**

O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** All those opposed?

**Nays**

Carter, Gigantes, O'Connor, Rizzo, Wessenger.

**The Chair:** The amendment is lost.

We then move to a Liberal amendment.

**Mrs Sullivan:** I move that section 11 of the bill be amended by adding the following subsections:

"Exemption

"(3.1) The factors listed in subsection (2) do not apply to an agency that is a municipality or board of health until the election or appointment of a new board of directors of the agency after the day this act comes into force.

"Same

"(3.2) A municipality or board of health referred to in subsection (3.1) may be designated as a multiservice agency if it satisfies the requirements for an approved agency set out in subsection 7(1)."

My view is that this particular amendment ought to be included despite the fact that the previous amendment which was placed by the Conservatives lost.

In the first place, if we look at (3.1), it says that the requirements of the board composition which would be included in 11(2) wouldn't apply to an agency that's a municipality or a board of health until the election or appointment of a new board after the act comes into force.

In other words, what we're saying is that the municipality and the organization which it selects, or the board of health, would have to adjust bylaws and create a mechanism whereby the board that would be directing the multiservice agency would have to include the one-third consumer representatives, the persons who are experienced in the health and social services fields, and that the board would also reflect the diversity of the community with respect to age, disability, place of residence and ethnic, linguistic and spiritual factors.

In other words, after the act comes into effect, if the community decides that a board of health or a municipality should become an agency, there would be time for the agency to adjust its board by changing the bylaws.

The second criterion of this particular amendment would require the same standards of the municipality or board of health. Those standards are: integrity, that they would be financially capable of providing the service, operated with competence, honesty, integrity and concern for the health, safety and wellbeing of the persons, and that the agency may receive financial assistance. No, sorry, that one isn't included, but clearly the financial capability and the integrity, honesty and concern for the health and wellbeing of the person are significant.

As I indicated earlier, subsection 19(1) of the bill, which comes later, would enable the agency, if it were a board of health, to file copies of the bylaws and each of the amendments to the bylaws subsequent to those amendments being made and as promptly as possible after they are made. What we're saying is that the agency, if it were a board of health, would not be required to have those new bylaws until after the act comes into effect. In other words, while the planning is

going on, the agency is not required to change its bylaws until it knows that there is some opportunity for it to become an MSA.

**Mr Jim Wilson:** I just have a question. I certainly appreciate the intent, which is the same intent as my previous motion with respect to this section. However, with respect to (3.1) here, I don't see it dramatically changing things; I'll give Mrs Sullivan a chance to elaborate or correct me. It says municipalities or boards of health are exempt "until the election or appointment of a new board of directors of the agency after the day this act comes into force." That's the part I don't understand, because it seems to me it's kind of the status quo as to the government's bill.

I don't understand how this is a vast improvement unless this is some sort of transitional thing that says, "Okay, between now and whenever this thing's proclaimed you can be an MSA" or something. I really don't understand it. Do you want to elaborate, Mrs Sullivan? The wording isn't clear to me.

**Mrs Sullivan:** The wording is the wording of legal draftspeople, and basically Mr Wilson is correct. It does indeed mean this is a transitional phase to ensure that the provisions with respect to the setting up of a multiservice agency wouldn't have to apply until the local decision-making came into play with respect to the board of health being recommended by the local community to be the multiservice agency.

I think the significant part of (3.1) would be that the boards of health would have an opportunity in that transition period to meet the requirements of the other agencies through their bylaws by adding individuals to their boards who created the same representative nature of the board required of other agencies; in other words, that the consumers would be involved, the health and social service providers would be involved, and the requirements with respect to the diversity of the board would still have to be met.

Similarly, the criteria for approval as an agency—capability of financially operating the agency, the issues of honesty and integrity and those of concern for the health, wellbeing and safety of persons receiving the services—are the identical criteria which apply to other agencies, and our view is that they should apply on an equivalent basis to the board of health or municipality, which of course the government has placed in a lower class, if you like, for approvals.

In many areas of the province, it would be very difficult to make the argument that the services provided under existing operations aren't exemplary. Certainly, in many areas an improvement in coordination is needed, an improvement in information flow is needed, but one can't fault the quality of the services provided where the provision of services is coordinated by or operates through the board of health or the municipality.

There is no reason to suspect that the same levels of quality being required of other agencies would or could not be met by boards of health or municipalities if the local community decided that that's who should be providing and coordinating the services, that that is who should be bringing the integration of community services

together, that that is where the access to long-term care should be placed. If that's what the local community decides, then that, in our view, is what the minister should respect.

The minister is setting out a template which is absolutely inflexible. As we've indicated, for some places in Ontario the board of health and the municipality being the MSA, considered on the same basis as any other agency would be considered, is the most appropriate model. Frankly, we think the inclusion of 11(3) is a slam at a very progressive section of our health and social services in Ontario.

**1700**

**Mr Jim Wilson:** I appreciate that explanation. It enables me to support the motion, given that I think (3.1) would allow for what Mr O'Connor and others on the government side have argued, that is, the election or appointment of consumers to the board of health, which is another way trying to get at the point we've been making that there's no good reason given to have a bias against municipalities and boards of health; they're key players in the system now. This should satisfy the government's desire, and I think all parties' desire, to see consumer input directly on these boards. Having had it explained to me a couple of times, I don't see much of a problem with it and will be supporting it.

**Mr Wessinger:** We'll not be supporting this amendment as it does conflict with subsection (3), which we previously rejected the deletion of.

**The Chair:** All those in favour of Ms Sullivan's amendment?

**Mrs Sullivan:** Recorded vote, please.

**Ayes**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** All those opposed?

**Nays**

Carter, Gigantes, Malkowski, O'Connor, Rizzo, Wessinger.

**The Chair:** The amendment is lost.

We then move to a government motion.

**Mr Wessinger:** I move that subsection 11(4) of the bill be struck out.

The reason is that it's now covered in subsection 11(1.1), which deals with the designation of multiservice agencies in multiple areas.

**The Chair:** Any discussion? All those in favour of Mr Wessinger's motion?

**Mr Jim Wilson:** I think we need a bit of debate on this prior to voting.

**The Chair:** I didn't have anyone down to speak, but if there is someone to speak, then speak on.

**Mr Jim Wilson:** It's hard to keep up with you, Mr Chairman; you're so, so efficient. Could you give us the purpose again, Mr Wessinger?

**Mr Wessinger:** The same item is covered in (1.1) as in (4), that is, "The minister may designate more than one multiservice agency for the same geographic area or part

of a geographic area." It's the same language, in fact, as far as I can see. It's already there, so it would just be having it in the bill twice.

**Mr Jim Wilson:** Oh, okay. I appreciate that.

**The Chair:** All those in favour? Opposed? Carried.

We then move to a Liberal amendment, subsection 11(4.1).

**Mrs Sullivan:** I move that section 11 of the bill be amended by adding the following subsection:

"Same

"(4.1) If there is more than one multiservice agency designated for a geographic area or for part of a geographic area, the agencies shall,

"(a) coordinate their efforts to provide community services to the area;

"(b) establish linkages, including the establishment of a common database, between one another; and

"(c) establish effective means of communication between their boards of directors."

**Mrs O'Neill:** On a point of clarification, Mr Chairman: How can we consider this when we've actually removed the section of the bill that this is to amend?

**The Chair:** This is a new subsection; this is (4.1).

**Mrs O'Neill:** I know, but it so directly refers to subsection (4). How can you have (4.1) when you haven't got (4)?

**The Chair:** It's fascinating, but I'm told you can.

**Mrs Sullivan:** Mr Chair, I think counsel worries about the numbering after.

**The Chair:** Yes, I think we'll sort that out. I am instructed by greater legal minds than mine that it is in order, so we'll have comments.

**Mr O'Connor:** In looking over this motion, I have some concern and have circulated a motion that I think would reflect the needs Ms Sullivan has addressed through her (a), (b) and (c).

**The Chair:** Just to be clear, that is the motion you've just circulated?

**Mr O'Connor:** That's right.

**The Chair:** Has everyone got a copy of that, just so we know what part of the hymn book we're singing from? Ms Sullivan, you've presented your motion. Mr O'Connor may later move another motion.

**Mr O'Connor:** In fact, I thought it may be seen as a friendly amendment. If Ms Sullivan would take a look at this motion and reflect upon it, she may wish to introduce it herself.

The difficulty that I can see within the Liberal motion is with regard to clause (b) with "the establishment of a common database, between one another." I respect the fact that as technologies change this will no doubt become a commonplace practice; today it isn't. If we were to put this in the legislation as the Liberal motion now stands, I feel it is being far too prescriptive. We're actually placing demands on the communities before they can decide for themselves what might be the best way of evolving the MSA to meet the needs of the community. I feel we're being far too prescriptive to put that in as has

been recommended by the Liberal motion. If Ms Sullivan would like to introduce the motion I've circulated, by all means use the wording in that motion. I would consider that a friendly amendment.

I don't even know whether all that has been stated in this motion is completely necessary, but I would leave that to counsel to discuss further if there are any questions placed. I would just suggest that the Liberal motion may be out of order because in a way it's going to demand dollars to be spent. I'll leave it at that.

**Mrs Sullivan:** My original motion, and I'll speak to it first, reflected concerns we had seen as local communities were attempting to come up with a model for their own multiservice agency coverage of the geographic areas within those communities with what has turned out to be, in many communities, in fact a less effective and more fragmented approach than had existed before.

I can use my own community as an example, where there had been one central point where services were accessed and now it appears that there are going to be at least four. In Toronto, we know the role and the place of Metro home care, and Toronto, it would appear, is going to move to anywhere from 19 to 26, and possibly more, multiservice agencies.

What is happening is that there is going to be substantially more fragmentation and no provision within this bill to ensure that the kind of coordination that occurred through existing services and systems will continue thereafter.

We also know that in many communities the linkages with other services in a continuum of care cross geographic boundaries. Whether it's relationships from the home care base with the facility-based services, with the local clinicians in terms of care, or whether it's a specialized care that might be available and required outside of the community, those matters, as you know, because our amendments looking at enhanced coordination and linkages were dealt with in a different way by the government, are of more than passing importance.

#### 1710

The one issue with respect to the communication between these new agencies and services as they're provided that came to the committee again and again and again was the necessity for there to be access to common information, to common data, that the same systems were used so that information could be recorded and accessed in the same way when services were found to be necessary outside the particular geographic area of the MSA; that if a specialized service had to be found in another MSA, for that MSA to be fully informed the paper trail was one that was operated through an electronic system rather than a paper system; that the database, including even assessment topics, if you like, was common one to the other.

If one organization is using a very different kind of approach or system, another agency which is supposed to be assisting and providing and adding to the seamless nature of care may well not have a full record of the needs of the individual nor of the services that have been provided in the past.

I find it, quite frankly, amusing that the government says this is too prescriptive, because this entire bill is so prescriptive that it's amazing to hear them say that. Having said that, I will withdraw my motion and place the motion as it has been drafted by the government.

I therefore move that section 11 of the bill be amended by adding the following subsection:

"Same

"(4.1) If there is more than one multiservice agency designated for a geographic area or for part of a geographic area, the agencies shall coordinate the provision of community services in the area and, to that end, shall develop various means of communication between each other."

The other concern that is still a massive one, and I believe we have addressed it to a certain extent—

**The Chair:** Excuse me, Ms Sullivan. Just so we understand, the amendment now before us is the one Mr O'Connor had—

**Mrs Sullivan:** That's right. I've withdrawn mine and I've read in the next one.

**The Chair:** Fine.

**Mr Jim Wilson:** I didn't even get to talk on yours. I thought yours was good.

**Mrs Sullivan:** You can still talk on it.

**The Chair:** Did you have any further comments you wanted to make?

**Mrs Sullivan:** The one issue that is still a matter of a very great deal of concern in this entire area is also reflected in our next motion: where there is specialization of an MSA and where there is need for particular services that cross MSAs. That coordination of information I hope is met not only through this amendment but through the amendment which will follow. I'm not quite certain that this amendment goes far enough; however, I will say that at least it's an improvement.

**The Chair:** Is there any further comment on this amendment?

**Mr Jim Wilson:** Ms Sullivan's original? I haven't commented on either of these things floating around here at the moment. I'd like to comment on both, so which one do you want to do first?

**The Chair:** The Chair will allow a very thoughtful linkage of the two.

**Mr Jim Wilson:** Okay. Well, the one that was withdrawn was very similar to the PC amendment for this section and that's why I'm supportive of it. I'm very disappointed that Mrs Sullivan withdrew her amendment. I was hoping she'd stick to her guns on that because the government's amendment, which is now on the table—it's in Mrs Sullivan's name but they drafted it—is just bunk. It doesn't have any teeth. It says something in general terms about if there's more than one MSA in an area they should be coordinated. That's just lovely, but the OMA, who originally asked for all of this, strongly recommended that:

"MSAs be closely linked where there are multiple MSAs in a geographic area in order to prevent not only duplication of services but to avoid gaps and fragmenta-

tion of service delivery. Linkages must include common databases"—which was contained in Mrs Sullivan's original motion—"the ability for individuals to move from one MSA to another within the geographic region, and close interaction and working relationship with MSA boards to ensure coordinated and integrated governance and decision-making," which is also included in the PC motion to come, so perhaps we'll debate it then.

I have to explain to the public here that what happens—I don't particularly like the government's motion, it's too airy-fairy to me. It's now Mrs Sullivan's motion but if it goes in any direction to helping the bill I'll support it, but I wish Mrs Sullivan had kept her motion on the table. I thought it was a better motion and it was very similar to the PC motion.

I'll support what she's got on the table now, but I'd also ask members, since we have to go in some sort of order here, to consider the PC motion coming up which talks about linkages through common databases, which a lot of groups asked for, including the Ontario Medical Association, and also a reference to integrated governance. I'd like the opportunity at that point to explain what we mean by that.

**The Chair:** We'll then put the Liberal amendment. All those in favour? Opposed? Carried.

We then move to the Conservative amendment.

**Mr Jim Wilson:** I move that section 11 of the bill be amended by adding the following subsection:

"Same

"(4.1) If there is more than one multiservice agency designated for a geographic area or for part of a geographic area, the agencies shall:

"(a) coordinate their efforts to provide community services to the area in order to prevent duplication of services and to avoid gaps and fragmentation in service delivery;

"(b) establish linkages through a common database; and

"(c) ensure coordinated and integrated governance and decision-making through close interaction and effective communication between their boards of directors."

I won't belabour this because I sense from around the table there isn't support, but the importance of this was the common database idea which is contained in the Common Sense Revolution in terms of a smart information system because we are told it is absolutely crazy. If you're trying to fix the system, why don't you put some teeth in this that actually fix the system?

We're told that people are discharged from hospital, their records are kept there, their X-rays are kept there. When they get into the home all the tests have to be done over again because the record doesn't follow them, there's no database to follow them. If different service providers go in, which is the case, their records are scattered.

I know that's one of the good things of your MSA in terms of trying to bring that together, but in terms of we should be integrating this between MSAs, what if somebody moves or because we're setting up specialized

MSAs for ethnic groups—there's a possibility with an amendment we passed earlier that a special AIDS MSA could be set up—we want to make sure there's a common database and I think the government should be moving towards that.

You are spending money now. You're going to put a photo on a magnetic card. You're taking the Liberals' useless health card, sticking a photo on it, rather than making the proper decision to come up with a smart information system for this province that links long-term care and the institutional side and all aspects of health care. That's what the plea is in part (c) of this bill.

Again, if we could get it into legislation maybe the bureaucracy would direct its attention and the government of the day would direct its attention to meeting the goals of this legislation and we would see a common database. But I don't see this legislation, as drafted or with the amendment that was just passed, as furthering that cause at all. I don't think things are going to improve that much with the new MSAs because you may have multiple MSAs.

In Toronto, if there are 20 MSAs and some specializing, how can we ensure, unless we put it in the legislation, that those files won't be stuck at one MSA and not available to the next MSA as the hospital files aren't available to MSAs now or community-based agencies? I just don't see you solving much in this system.

1720

Integrated governance: We thought that was important. The OMA, the medical association, thought it was important because you might want to allow for cross-appointments between MSAs, as we do in federated models with respect to other institutions in our society, where somebody who is sitting on one MSA may be cross-appointed to another so that you've got these formal linkages between them, not just leaving it up to their good will to get along.

There is going to be a competition for dollars in geographic areas. You're going to envelope funding. If you have more than one MSA in that envelope, there's going to be a competition between the two. I don't see how that's any different from what you tell us happens now in the system, competition between institutional care and community-based care. So if you've got multiple MSAs, let's do everything we can to integrate them, make sure there's a crossbreeding between the two and that we actually do accomplish something.

The motion that's on the table right now doesn't accomplish anything. It just says they shall coordinate, or they should. It's got no teeth in it. Why don't we try and do something with some teeth in it? If you've got to go with your model, let's make it the best model possible, not just keep paying lip-service to things that need to be fixed.

For instance, there's no mention of a phone number in this whole bloody bill. I tried to put that in and that was shot down. I don't see that you're any further ahead, other than you've got these nice, big bureaucracies set up all over the province; and the purposes of them—I don't know how you're going to meet those purposes, because

you won't put any teeth in the rest of the bill. That's all I have to say.

**Mr O'Connor:** I appreciate my PC colleague's intention here. In fact, I believe that by the motion as presented by Mrs Sullivan we've been able to accomplish what he's been requesting.

The unfortunate thing is that quite often we are our own worst enemies as members of the Legislature, because when people tell us we're far too prescriptive, we then end up with amendments coming up that are about as prescriptive as you can get.

I think that in time we will see the linkages through common databases as being presented today by Mr Wilson through this motion that I don't support. We'll see that come about as time evolves, but we're not about to mandate an MSA to develop common databases. As the needs of a community start to evolve and to reflect it, it's going to happen.

He suggests that somebody has to do this. Well, in fact the reform itself means bringing together many agencies. We are doing that and that's quite often what we are criticized for, actually doing what needs to be done in our eyes in pulling all these together.

I guess, from that, I'm just going to suggest to my colleagues that we don't support this motion. I think the Liberal motion brings together all of the elements that he wishes, except for the spending of money for a database that won't necessarily solve problems in and of itself.

**The Chair:** With that, we'll put the Conservative amendment. All those in favour?

**Mr Jim Wilson:** Recorded vote.

**The Chair:** Recorded vote. All those in favour of the Conservative amendment?

**Ayes**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** All those opposed?

**Nays**

Carter, Gigantes, Malkowski, O'Connor, Rizzo, Wessinger.

**The Chair:** The amendment is lost. We then move to the Liberal motion with respect to subsections 11(4.2) and (4.3). Ms Sullivan, if you would be so kind.

**Mrs Sullivan:** I move that section 11 of the bill be amended by adding the following subsections:

"Multiservice agency to service one community

"(4.2) The minister may designate an approved agency as a multiservice agency for a specified geographic area to provide services to a particular group or community within the geographic area.

"Same

"(4.3) For the purposes of subsection (4.2), a group or community includes a group of persons based on the persons' age, gender, disability, culture, race, religion or language."

This amendment, I think, is a very important one in ensuring that the real community needs are met through an MSA. If we look at the entire question of children and

children's services, it seems to me that the approach of lumping children into an MSA where all disabled and all seniors' concerns are being dealt with will mean that the children will get short shrift. We are very uneasy at what appears to be less than full thought given by the government to the entire question of long-term care for those children who require it.

The issue of the children's treatment centres and where and how they fit, the issues of special services that are provided now through home care in the schools, the issues of the particular psychological and behavioural problems that children with longer-term disabilities have we feel may well be subsumed by priorities which are given to adult individuals with disabilities or with long-term care needs, as in the case of seniors.

The other issue is the issue with respect to facilities that are available, and when I say "facilities," I'm not using it in the sense of the word "institution" but the availability of services for those people who have a cultural or an ethnic or religious, a spiritual need that is in itself a part of the need for satisfaction if there is going to be a solution to whatever problem exists. I think of the kinds of services that have been provided, say, in Metro through organizations such as the Villa Colombo, through the Baycrest Centre, through other organizations that have specific mission-based structures or culturally and ethnic-based structures.

In Bill 101 you will recall that much of our emphasis was to ensure that for groups and organizations, such as, by example, the Japanese, who wanted facilities that were available in their language, although it's not a requirement of our language services, those facilities and services would be available in a time and a way that were sensitive to the particular needs of seniors who only knew one culture and one language. While that will probably be less of an agency, of an MSA, creation in terms of the ethnic and cultural links, the opportunity to facilitate those MSAs for specific purposes we think is one that should be considered in this bill.

The issue of the deaf is one that we heard very strongly during 101, in that the presentations that were made to us spoke of deafness as a linguistic issue rather than as a disability issue, and I was quite taken with that discussion. There was no question that the arguments that were put before the committee provided us with a vehicle for understanding the particular culture of the deaf community, the particular experience and the need for a particular communications method and understanding of the experiences that were unique to the deaf community. At the time, in Bill 101 when the issue of an MSA for the deaf was raised, there was no question that representatives who appeared before our committee thought that was a viable option and one the community itself should consider.

Now, whether or not the deaf community will decide that there ought to be one MSA that reflects a certain organizational status or whether there are problems within the deaf community that would preclude that or that would mean there would not be an MSA, once again it seems to me that the opportunity for a community, which would in this case be defined other than on a geographic

base, unless the geographic base was perhaps Ontario, the opportunity for that MSA to be formed should be a viable one and should be available.

#### 1730

Similarly, we have heard the strong representations from individuals who are HIV-positive or who have AIDS with respect to an MSA that met their particular needs in a sensitive way and that could be developed on a geographic basis to ensure that the issues that are so important to that community—whether they're privacy issues, whether they're issues associated with counselling, whether they're issues associated with assistance in the actual provision of care in the home or in the community—that the sensitivity is assured through the opportunity for a separate MSA for those with that particular illness and disability.

I think what this amendment is saying is that the separate MSAs ought not to be required, but when the community need is expressed and when the will of the community indicates that there is a need and a wish for these separate MSAs that reflect either the culture or the disability, that opportunity should exist and it should be included in the legislation. We put this amendment forward for your consideration.

**Mr Gary Malkowski (York East):** I'd like to respond to the comments that Mrs Sullivan has made. I just want to clarify what you mean by a group. You have culturally deaf people, aurally deaf people, deafened people, hard-of-hearing people, and these are all separate groups within the deaf community. So do you mean MSAs providing services to each of those groups serving each of their varying needs or do you mean all into one MSA?

**Mrs Sullivan:** I think, as I've indicated, those are issues that a particular community would have to decide on its own. The flexibility ought to be included in the bill to ensure that if, by example, a community of deaf people came together or a community of AIDS people came together and said, "It is our wish that for this specific geographic area a multiservice agency be set up with the appropriate consumer representation, with the appropriate health and social services experts and with the appropriate range of other representatives on the board," if the community itself came together and said, "This is what we want and this is the way our services would be organized," the flexibility should be included in the bill to enable that to happen.

It should not be a requirement of the bill and it would certainly not be our intent to say that for the deaf community, by example, there must be an MSA, or for people living with respiratory illnesses there must be an MSA or even for children there must be an MSA. But where the need is felt and expressed and where people as a community have come to terms with the issues and the questions and the needs to address those questions, given the mandatory basket of services that's required under this bill, given the requirements for quality assurance and for quality management, given the requirements for the financial capability and for the agency to operate with integrity, which is a significant part of this bill, then the flexibility ought to be included in the legislation to ensure

that where there is that expressed need that is a considered one, the minister ought to be able to consider the approval of an agency to meet special and certain needs.

**Mr Malkowski:** Just to follow up on your comments concerning disability groups, there are several disability groups such as the blind, so is the intention of your motion that each group should be setting up an MSA for, say, the blind or for other of the varying disability groups?

**Mrs Sullivan:** My sense is that there are many groups of people who are well represented by organizations that would say that their needs would be better served through a geographic-area-based multiservice agency approach. There are some other organizations, however, within a geographic area—by example, all of the GTA or all of southwestern Ontario, or indeed all of Ontario—that might feel they would prefer that a multiservice agency be the body that participates with them in the assessment, where they are involved and participate in developing their own plan of service and so on, and where, according to the will of that community, the minister ought to be able to consider an application for designation of the agency if it meets all of the other requirements of forming an agency.

I don't see this as something where a lot of people who are classified by disability would say, "Yes, we think this is the best thing." I don't think a lot of groups would. On the other hand, there may be groups of individuals, of people who share a common cultural approach or who share a common disability or who share a common spiritual approach to their long-term care requirements who would want a multiservice agency to meet their needs. Once again, this would be enabling: It would allow the minister to consider a request with a full application that met all of the other needs for designation of the agency as an approved agency and then as a multiservice agency.

**The Chair:** Just before going on, I'm going to ask the parliamentary assistant to make a comment, because he believes that this has already in fact been covered.

**Mr Jim Wilson:** I was just going to do that for him.

**Mr Wessenger:** Yes, we previously passed a motion, subsections 11(1), (1.1) and (1.2), which permitted the minister to designate an approved agency as a multiservice agency for

"(b) those persons in a specified geographic area who require community services and who can be identified by,

"(i) their membership in a specified ethnic, cultural, religious or linguistic group, or

"(ii) any other prescribed characteristic or prescribed combination of characteristics."

What I'd like to suggest is that it's already been covered with an amendment.

**The Chair:** Mrs Sullivan, do you—

**Mrs Sullivan:** I just have to find it, Mr Chairman. I'm looking through my—

**The Chair:** Mr Wilson, do you want to just comment while Mrs Sullivan is looking?

**Mr Jim Wilson:** I recall the debate when the govern-

ment introduced subsection 11(1) and appreciate that, but you can see that the intent of Mrs Sullivan's motion is similar to the PC motion that's next, and I just want to read that.

**The Chair:** I'm sorry, but just to be clear, the next one is subsection 11(5.1)?

**Mr Jim Wilson:** Yes, subsection 11(5.1).

**The Chair:** And to help us all understand this debate you think it would be useful if you just commented?

**Mr Jim Wilson:** Because it's very similar, and I need to make a point after I read it.

"The minister may, as a term and condition of a designation, require a multiservice agency to only provide services to a group of persons specified in the designation, and may specify as a group persons who are under 16 years of age, persons who have contracted the acquired immunodeficiency syndrome or any other persons who form a group based on age, gender, disability, culture, language, religion or race."

1740

So you see, our motions are very similar. I'm supportive of the Liberal motion because it is similar to the PC motion, specifically because here it does deal with children and it does deal with, in the PC motion, persons living with AIDS. We kind of think that's important, to ensure that that is on the record, that that is the intent.

I'm willing to take the parliamentary assistant at his word that 11(1) includes all of this. I think what we've had in the last five minutes is a very good debate and quite necessary for this bill. However, at the end of the day I think the legal interpretation would be that both Ms Sullivan's and my motions would be somewhat redundant at this point.

**The Chair:** If that is agreeable, then what I understand—

**Mr Jim Wilson:** One more point.

**The Chair:** Sorry, one more point.

**Mr Jim Wilson:** The reason these are in there, Mr Wessenger, is that you talked about single-purpose bodies. To me the general rule for an MSA is it's not a single-purpose body, other than the single purpose, I suppose, of long-term care services. To me, though, that's a pretty big umbrella. What this enables you to do and what 11(1) enables you to do is to do those single-purpose bodies that you referred to. I guess it's a splitting of language hairs here, but—

**The Chair:** It's an interesting kind of hair.

**Mr Jim Wilson:** When you're doing legislation, it's amazing what terminology you come up with.

**The Chair:** What you can split.

**Mr Jim Wilson:** Anyway, I suppose we should have the vote so we can get on with this.

**The Chair:** I think there is an understanding that perhaps this has been covered, in view of the content. Ms O'Neill did request to speak on this, so I would allow her to make her comments and then I would ask Ms Sullivan and Mr Wilson if they are prepared to withdraw their amendments in light of what has just been said.

**Mrs O'Neill:** I think the reason this was maintained by our caucus was that there is still in people's minds, and certainly in the letter we got today from the Catholic Health Association of Ontario, doubt about what "community" means.

There is no definition of "community" in the bill. This particular amendment states that a group or community includes a group of persons. We are trying to get a definition of the word "community." If that is not going to be acceptable, we will have to push at another spot where "community" may come into the bill.

**The Chair:** Ms Sullivan, did you want to withdraw your motion?

**Mrs Sullivan:** As I'm going back through my notes, actually, I note that on my notes on the government motion to section 11(1) and so on, I have "Consider with Liberal amendment, 11(4.1), (4.2) and (4.3)." So I'm sorry that I put this motion forward. I will withdraw it, but on one condition, that I have satisfaction that the age factor is covered in "any other prescribed characteristic or prescribed combination of characteristics," because once again the children's services issue is one that we feel is strikingly difficult.

**Mr Wessenger:** I'll be very happy to reconfirm that, because I did indicate before that (b)(ii) would include the age.

**The Chair:** With that, then, Ms Sullivan, you withdraw your amendment. Mr Wilson, you have not put yours, so I will not ask you to withdraw that which was not put.

There were some amendments within section 11 that dealt with first nations, and those were stood down to be dealt with later, so I will not put section 11 at this time, because we have not dealt with those motions. Just so people—

**Mrs Sullivan:** I'm wondering if the government would consider, since section 1 of the bill is still open for the same reason, bringing forward a definition of "community" that would be appropriate for this bill and including it in that section when we come back to it later on.

**The Chair:** I'm sure they'll take that under advisement.

At this point, just before moving to section 11.1, I'm going to ask the parliamentary assistant: There was a point of clarification that you wished to make. Given the hour, this is perhaps the best time to do it.

**Mr Wessenger:** Yes, there was a comment made at a previous meeting that a Mr Doug Jackson had sent out a memo indicating that persons who sat on the boards of service providers could not be members of MSAs, and I'd like to put on the record that that was not correct. Mr Jackson never made such a statement. What Mr Jackson's fax stated was that, first of all, with respect to MSAs:

"MSAs must ensure that some board members have experience in the health and social service fields. This goal can be reached by involving volunteers, service providers, advocates, professionals and front-line workers in the health and social service sectors."

Where I think the confusion arose was with respect to

the provisions pertaining to conflict-of-interest guidelines, and what is stated there is:

"Each MSA should have conflict-of-interest guidelines which preclude members of the board with a pecuniary interest in matters relating to the business of the MSA from participating in discussion, influencing voting or voting on a particular matter before the MSA," and "a pecuniary interest would include membership on the board of directors of both the for-profit and non-profit organizations that have service arrangements with the MSA."

So it's a normal prohibition with respect to a person, any person, sitting on the board dealing with a matter in which they would have a pecuniary interest.

Maybe I should file the memo from Mr Jackson with the committee so that it would be on the record.

**The Chair:** Okay, and I believe members have a copy of this memorandum.

**Mr Wessenger:** Oh, do they?

**The Chair:** Is this the one that was passed out, August 22?

**Mr Wessenger:** Yes.

**The Chair:** I think we all have a copy of that. Mr Wilson, did you wish to—

**Mr Jim Wilson:** What's done is done, and I appreciate Mr Wessenger's clarification of that and reading it into the record. I think that's important. But given that there's a great deal of uncertainty out there, Mr Jackson circulating memos about a bill that's before Parliament is inappropriate.

When Parliament is supreme in this province, and the Parliament of Canada is supreme in Canada, you don't have bureaucrats, no matter how well-intended, circulating memos about what the interpretation of an act is going to be when that act has not gone through Parliament, and that is what I think I resent.

Secondly, for the record, for a number of groups that brought this notion to my attention, that Mr Jackson was in some way sending a message out to preclude members of current server-provider agencies from serving on MSA boards was their interpretation of parts of that memo.

It would be very helpful, and I think the practice has probably stopped, but given that Parliament hasn't spoken on this bill yet, I don't think we should be circulating any more memos about what the intent of the legislation is or in fact what the interpretation of the legislation is, given that this legislation has not passed this Legislature and may not pass this Legislature, I think, once the people of this province continue to voice their concerns about this legislation.

**The Chair:** I'm going to ask the parliamentary assistant to comment again. Because there is also a member of the committee named Jackson, I just reiterate that this memorandum is from Mr Doug Jackson, office of the special adviser, MSA implementation.

**Mr Wessenger:** I'd like to respond by indicating that if one is to have a planning process, you have to give guidelines with respect to the planning process, and also it should be clear that it's an explanation of what Bill 173

states. It does not say that is the law; it just states it's an information piece with respect to the bill before the Legislature.

**Mrs O'Neill:** I find this discussion quite interesting, because certainly what Mr Wessenger is saying is exactly what people are objecting to. The district health councils found this quite offensive, and we've had letters to this committee about this matter.

They are in the planning stages. We have one district health council that's brought in a preliminary plan. The other 31 have not brought in their plans, and they're being told who is a voting member of the MSA, how the first MSA board of directors is going to be formed, and of course that the ministry and the district health council are going to have to approve that whole process. Every single guideline and bylaw is almost determined here. There are no specific requirements for board size is about the only thing I can see flexibility in.

The people who are having trouble with the governance structure of MSAs find this whole thing very prescriptive, and I certainly agree with those who are saying that this kind of thing should not be circulated as we're in discussion on clause-by-clause. Surely, some of the things we're saying, and we are saying things that we've heard and other members of this committee have heard, will then have an effect on how the guidelines, and indeed the regulations, hopefully, are determined. Many who have come before us have said they want to be here when the regulations are determined.

1750

**Mr O'Connor:** I recall this memo fairly well because I'd suggested that we circulate it a little bit more broadly as we heard about more of this. So I guess you can look at me as a guilty party for trying to be more open about this. Unfortunately, or fortunately, there is so much interest within the reform of this long-term care that the DHCs are actually out there with their sleeves rolled up, working on it, and so when they asked for information, the DHCs—

*Interjections.*

**The Chair:** Order.

**Mr O'Connor:** —then an information package went out to them. I hear where my colleagues are coming from. It certainly shows the enthusiasm for this long-term care reform. If there's any problem here, it's trying to eliminate some of the confusion that sometimes members of the committee here, for example, perpetuate by bringing out a lot of unfortunate rhetoric that we're all guilty of at times.

But I know where this comes from and appreciate the concern. I certainly applaud all the hard work by the DHCs out there currently working on the long-term care subcommittees, trying to work towards this MSA today.

**The Chair:** I wonder if I might suggest to the committee—I show about eight minutes of the clock. We can proceed to begin with 11.1, which is the next section, or we can wait and begin tomorrow. I'm in the hands of the committee.

**Mr Jim Wilson:** I think, Mr Chairman, we could go ahead with 11.1.

**Mr Wessenger:** I think so, yes.

**The Chair:** All right. Mr Wessenger agrees with this strong sense of unanimity around the table. It is with courage that I turn to Ms Sullivan for section 11.1.

**Mrs Sullivan:** I move that the bill be amended by adding the following section:

"Limitations on service

"11.1 Despite anything in this section, a multiservice agency shall not provide community services to a person who is a veteran within the meaning of the Department of Veterans Affairs Act (Canada)."

As I present this amendment, I will tell you that I was quite puzzled with the approach of the legislative draftspeople in the way they looked at this particular amendment. The intent here is to satisfy the needs of the veterans' community that appeared before us that want to ensure that none of their rights are lost through the multiservice agency process, rights they have been granted under the Department of Veterans Affairs Act. Mr McGuinty is particularly well informed in this area and, as I say, just the legal draftsmen's approach to solving the problem of not having their rights interfered with.

**Mr Jim Wilson:** Certainly, it's the right intention here, but clearly the wrong wording. I think it doesn't make any sense the way it's worded, but I give the Liberal Party full credit, and let's do that now, for wanting to make sure that this act doesn't interfere with the rights of veterans.

I'd ask members to consider this. If people refer to the PC amendment to add 57.1, it says, "Nothing in this act shall affect, negate or derogate from any right, priority or service given veterans under the Department of Veterans Affairs Act (Canada)."

I think that's a better, all-encompassing clause, and perhaps in a non-partisan way we could agree that it is a better clause and when we get to 57.1 agree to put that in. It's all-encompassing. It's the exact, same good intentions and intent that Ms Sullivan has, but without this wording that's in the Liberal motion which I think is very problematic because it almost cuts people off services.

That's a real problem and I know that wasn't intended, so I draw your attention to that 57.1 amendment. Maybe when we get there we could have all-party agreement and actually put it in and maybe actually get the government to agree on this.

**The Chair:** I'm just trying to find 57.1.

**Mr Jim Wilson:** It's about an inch into your package.

**The Chair:** Yes, here we are. Now your suggestion is that—

**Mr Jim Wilson:** If Ms Sullivan—she's already put on the record the intent here and I think it's a very good intent, shared by all parties, I hope—would perhaps consider either withdrawing or something—because I think if we really want to debate this motion, it raises more problems than it tends to fix.

**The Chair:** I've got Mr O'Connor and Mr McGuinty while Ms Sullivan contemplates, and then the parliamen-

tary assistant. Has everybody got 57.1, so they can just sing along?

**Mr O'Connor:** I would agree with the sentiment that my colleague has presented. I'm not sure that provincial law would have any jurisdiction in this regard—I guess we'll probably need some advice from counsel on that—and would suggest that we're probably better off to wait until we get to the point where we're actually dealing with Mr Wilson's clause, because for the reasons he's pointed out, I would be fearful that we start limiting veterans' services, not intentionally, but by wording it as represented.

**Mr Dalton McGuinty (Ottawa South):** Our intention here when we gave some thought to this amendment was to ensure that the special rights afforded to our veterans under federal legislation were not in any way adversely impacted by this bill. I think the wording of the PC amendment is more comprehensive and simply better drafting than the one that's found in ours, so my recommendation to Ms Sullivan is that we go with Mr Wilson's suggestion that we deal with his amendment when we get there.

**Mrs Sullivan:** I'll stand this amendment down then until we get to that amendment and withdraw it at the time. Can I do that?

**The Chair:** Do you want to stand it down or do you want to move—

**Mrs Sullivan:** I could withdraw this one and move Mr Wilson's amendment.

**Mr Jim Wilson:** Not bloody likely. Anything's possible, but not that. I really like Mr McGuinty's comments. We should let it stand at that.

**The Chair:** I'm in the hands of the committee. There is not agreement among everyone here on this. With unanimous consent, we could deal with that motion and then have dealt with this.

**Mrs Sullivan:** That's a good idea.

**Mr Wessenger:** I ask that we deal with it in sequence. We certainly support the intent of the motion, but I think legal counsel wants to look at it.

**The Chair:** I knew we were on too much of a roll.

**Mr Jim Wilson:** Let's saw it off here: If Ms Sullivan wants to stand it down, I'd agree with that in terms of it keeps the government's feet to the fire that it has to deal with veterans. So it's still on the table then, but stood down for now.

**The Chair:** Fire or ice water. All right. Then we will stand this down, Ms Sullivan, and when we get to 57, we will deal with these two together.

With that, it being almost 6 of the clock, I think we will adjourn until 3:30 or after routine proceedings tomorrow in this place.

*The committee adjourned at 1800.*

## CONTENTS

Monday 31 October 1994

**Long-Term Care Act, 1994**, Bill 173, *Mrs Grier* / **Loi de 1994 sur les soins de longue durée**,  
projet de loi 173, *M<sup>me</sup> Grier* ..... S-2489

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York-Mackenzie L)
- \***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- \*Carter, Jenny (Peterborough ND)  
Cunningham, Dianne (London North/-Nord PC)
- \*Gigantes, Evelyn, (Ottawa Centre ND)  
Jamison, Norm (Norfolk ND)
- Martin, Tony (Sault Ste Marie ND)
- \*McGuinty, Dalton (Ottawa South/-Sud L)
- \*O'Connor, Larry (Durham-York ND)
- \*O'Neill, Yvonne (Ottawa-Rideau L)
- \*Rizzo, Tony (Oakwood ND)
- \*Wilson, Jim (Simcoe West/-Ouest PC)

\**In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham  
Malkowski, Gary (York East/-Est ND) for Mr Martin  
Sullivan, Barbara (Halton Centre L) for Mr Eddy  
Wessenger, Paul (Simcoe Centre ND) for Mr Jamison

#### **Also taking part / Autres participants et participantes:**

Wessenger, Paul, parliamentary assistant to Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gottheil, Joanne, legislative counsel

CAZON  
XC 12  
-577



S-76

S-76

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 1 November 1994

# Journal des débats (Hansard)

Mardi 1 novembre 1994

Standing committee on  
social development

Comité permanent des  
affaires sociales

Long-Term Care Act, 1994

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

*1944–1994*

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 1 November 1994

Mardi 1 novembre 1994

*The committee met at 1553 in room 151.*

## LONG-TERM CARE ACT, 1994

## LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Acting Chair (Mr Dalton McGuinty):** Welcome to the continuing clause-by-clause hearings into the matter of Bill 173, An Act respecting Long-Term Care. We are to begin today with consideration of section 12. I understand the government plans to move a motion.

**Mr Paul Wessenger (Simcoe Centre):** I move that section 12 of the bill be amended by adding the following subsection:

"Same

"(1.1) Subject to sections 20, 21, 22 and 31, a multi-service agency shall provide or ensure the provision of a range of the community services mentioned in subsection (1) for palliative purposes and a range of the community services mentioned in subsection (1) for respite purposes, in the geographic area for which the agency is designated."

The purpose of this amendment is to respond to the concerns raised by some presenters at the hearings that palliative and respite care were omitted from the list of mandatory services.

**Mr Jim Wilson (Simcoe West):** On the surface I think we want to support this particular amendment put forward by the government, particularly in that it mentions respite care and palliative care, which were two very serious matters that were brought to our attention that for one reason or another were not clearly delineated in the original drafting of the bill.

I know it's the intention of the government to try and satisfy those individuals and families and caregivers who wanted the reassurance that palliative care and respite care were part of the MSAs' mandate, and I think this bill should do that. I know opposition parties through various means also tried to get this language in the bill, and for a number of reasons, I think the government actually might have accomplished something with this one amendment.

**Mr Larry O'Connor (Durham-York):** I want to support this motion and respect some of what we heard as we went through the committee hearing process. It was my understanding that in the drafting of the bill, the intention for respite care and palliative care was always included in there, though it wasn't defined in a way that was very easily recognized.

I guess that's a problem we always face when we have legislation, with no malice towards our legal counsel, drafted by counsel, that sometimes when it's being read by people, for example, the fine people who made presentations—that's why it was brought to our attention as such. I think this spells out more clearly the intention that was intended in the bill right from the beginning, and we'll be supporting this motion.

**Mrs Barbara Sullivan (Halton Centre):** We'll be supporting this amendment. There are a couple of things that I'd like to point out with respect to the amendment. First of all, the addition of care that's provided for palliative reasons will be largely professional care, although there may well be what traditionally had been known as homemaking issues that are associated with it, but for the most part they will be personal support services and professional services for palliative care.

I think it should be very clear to people who were concerned as the debate was proceeding and the public hearings were proceeding over the summertime that under the legislation then there would be no additional charges for services that are personal support services or professional services.

There may well, however, be additional charges for services that are community support services, including the friendly visiting and the security checks and so on, as well as for those services which are homemaking. We think people should understand that the addition of palliative care and respite services doesn't mean that these are services which are provided, as they have been most frequently in the past, as insured services, that there may well be new charges associated with those parts of the services that are now community services and homemaking.

The respite care we feel is a good addition to the bill. We recognize that the government has included it in more than one amendment and we appreciate that. We feel the need is strong and the evidence of misunderstanding about the purposes of the inclusion of respite was large.

**The Acting Chair:** Is there any further debate? All those in favour of the motion? All against? Motion carried.

**Mr Jim Wilson:** I move that section 12 of the bill be amended by adding the following subsection:

"Same

"(1.1) In addition to the services mentioned in subsection (1), a multiservice agency shall, within one year of its designation, make available and operate a telephone service which will enable a person to access information

on all community services available in the geographic area in which the person resides by dialling a single number."

The intent of this amendment, and indeed the purpose of this amendment, is to ensure that one of those things that we heard during the consultation process over the last couple of years, in which the government claims to have heard from 75,000 people—I think one of the things that jumped out at us as I attended some of those meetings and read reports about those meetings and had people meet with me in my office and in my riding was a common theme that a telephone service would be set up by these multiservice agencies, that that was clearly more important.

**1600**

In fact, I never heard anyone mention to me personally or while I was in a room that they wanted what the government has done; that is to say, on the other hand, that the MSAs, rather than setting up a coordinated telephone service and one-stop access and coordinating services, the government has moved towards an 80-20 rule where not only will the MSA be doing a degree of coordination, but in fact it's amalgamating all the existing agencies. But we'll get to that in section 13 again.

This is one of those very important services that was part of the sales job on this phase of long-term-care reform, that the expectation was put out there that agencies would be required to have one phone number for a geographic area. Therefore, while arguments I suppose could be made that you need more than a telephone service to be accessible, I agree this motion certainly doesn't prevent anyone from walking into an MSA office to get services, nor does it prevent persons from contacting the MSA in any other way that they feel comfortable in doing.

Therefore, I would ask members to support this. It's the second attempt I've made to try and put tangibly in this legislation one of the things that certainly consumers asked for during the several rounds of public consultation that preceded the introduction of this bill.

**Mr Wessenger:** I'd like to indicate, first of all, I don't think anyone in this committee would disagree that an MSA that's set up ought to have a simplified information access system, including a single telephone number. I might as well say that at the beginning. I don't think anyone disputes that this would be reasonable for an MSA to do. In fact it would perhaps be difficult to understand why an MSA wouldn't do that.

But I think the language of the motion, first of all, is somewhat problematic and the words "operate a telephone service" could be construed rather broadly. Also I think we're being somewhat overly prescriptive.

**Mr Jim Wilson:** Okay, here's the deal: You can get rid of all the other prescriptions; keep this one.

**Mr Wessenger:** I think we ought to have some confidence in the ability of the board to manage the MSA.

**Mr Jim Wilson:** Have you finished?

**Mr Wessenger:** Yes.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** This amend-

ment confuses me because there are so many agencies out there now that do this kind of thing. I'm thinking of even the government-supported body of the community information centres. They're well established in many communities. Many of the municipalities put out numbers that are useful. Indeed, we ourselves, many of us, do that as a public service. I certainly feel it's part of my role.

To have the wording "information on all community services available in the geographic area in which the person resides by dialling a single number" I'm not even sure that's possible. Secondly, I just don't know whether it's feasible. I wonder what would happen to the role of the other groups which feel the need and necessity to, first of all, be connected with the services in their community and then to take the responsibility of informing the community about them.

I really don't think as the wording stands that we could place it. I think, if there is a need for telephone service and access to telephone information, that it could be much more part of the regulations than part of the legislation.

**Mr O'Connor:** It's an interesting motion and I appreciate where my colleague is coming from on this. In our last day of deliberations he talked about a common database and he is intent in seeing some hardware-software in the offices that is going to improve access to information and sees a telephone service being operated by an MSA as the fashion in which to do it.

No doubt there will be a telephone service of some nature being put together on the best of advice from the MSA. I'm sure that, as the MSAs do get up and running, this is something they're going to make sure they offer, a service which is going to be most accessible for the consumer.

I relate to a local circumstance within my riding. A constituent of mine who lives in, for example, Sunderland, my home village, which is policed by the Durham Regional Police, has one access number. That's down in Oshawa, which relays it back up to Sunderland. We can't phone the Sunderland detachment from Sunderland. So if an MSA decides that the best way to service the local community is going to be by having—for example, Brock Good Neighbours offer that service up in Brock—or whatever does evolve out of this, if that's how they do it. Having people phone Oshawa to get back up to Sunderland or Cannington or Beaverton just doesn't make an awful lot of sense to me.

I appreciate where the member is coming from, but to start prescribing the hardware and office equipment that an MSA is going to be using I don't think is—talk about prescriptive; I think that's extremely prescriptive.

**Mr Jim Wilson:** It's a bloody telephone.

**Mrs Karen Haslam (Perth):** Calm down.

**Mr Jim Wilson:** Surely to goodness, they're going to have a telephone.

**Mr O'Connor:** We are then, you know, telling people what they should be putting in place in the daily operations of the MSA, so I wouldn't support this. I appreciate the intent that he has here—

**Mr Jim Wilson:** It's a telephone: "Hello. Ring, ring."

**The Acting Chair:** You're next, Mr Wilson.

**Mr O'Connor:** With that, Mr Chair, I know that Mr Wilson would like to comment, so I would agree to let him have the floor.

**Mr Jim Wilson:** As calmly as possible, I just remind Ms O'Neill that her comments didn't make any sense in the context of this bill, because the language of the amendment talks about community services. The community services in the subsection (3) that deals with it—I've got to get the right section here; I think it's 2(3). Mr Chairman, can I just take a moment to consider the government's—but I do want to correct Ms O'Neill.

What we're talking about are community services; not all those things that MPPs do, but community services within the definition of the bill. Those are the community services that must be delivered 80% by the MSA, so of course they're going to have a phone. We just want to make sure they have one phone number to access these services. I just don't understand the comments I've heard from members. It doesn't make any sense whatsoever actually.

**Mrs Haslam:** Next you're going to tell them the numbers they can have.

**Mr Jim Wilson:** Oh, for goodness' sake.

**Mrs Sullivan:** Oh, oh. You're telling the nursing homes what kind of mouthwash they can use.

**The Acting Chair:** Mr Wilson, are you done then? For now, I mean?

**Mr Jim Wilson:** I am, Mr Chairman. Thank you.

**Mrs Sullivan:** We will not be voting for this amendment, but I want it to be made very clear that we believe that fundamental to the operation of a multiservice agency and fundamental to the need for information services is a communications system that is coordinated in full. I think this particular amendment makes a reference to only one particular type of communications vehicle. There are many others.

There are computer networks that are available through the libraries in many communities which can act as resources for individuals who are seeking information. There are other media outlets. There is print material. There are, in many local communities, services through cable television and other broadcast vehicles.

There are other coordinated health services information mechanisms that are available, whether it's through facilities or through institutions, whether it's through the community information services and so on. To limit a communications strategy by identifying one particular communications tool I think is an inappropriate way to go, so we will not be supporting this amendment.

1610

**Mr Jim Wilson:** Well, that is all very nice but misses my point. But I'm getting used to that.

The government has very kindly suggested a better placement for this motion and better wording, which I'd like to read at this time, and withdraw this motion. But before I do that, I'd just like to read without indicating what section this will go in. It'll go in in a later section. It says:

"An MSA shall make available a single point of access to information on all long-term-care community services in the geographic area for which the MSA is designated, including but not limited to a telephone number which is widely advertised."

The suggestion from legal counsel is that it be put in as an addition to subsection 14(1.1). When we get to that section I'll be reintroducing this amendment and withdrawing the one regarding section 12 at this time.

**The Acting Chair:** You're withdrawing your motion at this time then, Mr Wilson?

**Mr Jim Wilson:** Yes, thank you, to replace it later.

**The Acting Chair:** Thank you. Next we have a Liberal motion.

**Mrs Sullivan:** I move that subsection 12(2) of the bill be amended by striking out "if the minister authorizes it to do so" at the end.

One of the fundamental premises and purposes of this bill is to ensure that there is a minimum basket of services that are available everywhere in Ontario where the equity in access to those services is eased significantly.

The options are and would be available for additional services to be provided through a multiservice agency, and the provision of this particular section is that a condition is attached to the provision of additional services, that the intervention and authorization of the minister for a local MSA to determine what needs in the local community have to be met and whether they can and ought to be provided under the aegis of the MSA.

We feel that the local planning process and the local identification of needs should be adequate in decision-making about whether additional services would be offered, not the least of which may be services that respond to particular cultures or conditions that in fact do not require the authorization of the minister.

In children's services, the entire role of children's treatment centres and the coordination of those centres with services that are provided for MSAs and under the 80-20 rule is problematic. The provision of specialized services for children or for others who require those specialized services where there is a population-based need or demographic need we feel is something that the local community should determine, and the local board, which will by law require the participation of consumers, providers and others from the community who have clearly an interest and an expertise in the area of long-term care, should be adequate for the board to make this decision, rather than having to haul off to the Minister of Health on every kind of additional service that the MSA may want to offer.

I suggest to you, by example, that adult day programs may not be specifically included in some of the ways that a local MSA may want to include them. While physio and occupational therapy and speech therapy may be included, there may be other elements of programs that could be done through adult programs, and I'm thinking of areas such as oral hygiene clinics that could be done on a day basis where people can go to a central point or where the MSA may decide to offer those services to

people who are confined to their homes and receiving other care.

We don't think that the MSA should have to run off to the minister on each of those occasions to ensure that appropriate and needed services are provided. So our recommendation is that the ministerial authorization be removed. We feel that if this government has any belief in the viability of community-based services that are in fact community-run, it will concur with us and remove that line.

**Mr Wessenger:** I certainly understand the member's point of view of providing additional autonomy to a multiservice agency. But I think the concern with deleting the provision is that what the ministry wants to ensure is, first of all, that the basic, mandatory services continue to be provided by the multiservice agency, and it also undoubtedly would want to ensure that the multiservice agency has the capacity to deliver the additional services. Certainly for that reason it would like to have some approval process, with respect, but it's certainly not the intention to restrict. It would only be a restriction on the basis that it would impair its ability to provide its basic services.

**Mr Jim Wilson:** I'm just wondering, though, if the parliamentary assistant doesn't feel that the current wording, which contains that the minister authorizes it to do so, isn't too prescriptive, to use the language that's being thrown around here, and further, isn't too restrictive in terms of I don't think you can have it both ways in this legislation. You can't keep saying in your press releases and public statements that this allows MSAs and communities to enjoy a large degree of flexibility when clearly that isn't true.

Here again, if the agency came up with something creative and innovative and wanted to try it at a local level and it was a local initiative, I don't know why it needs to get Queen's Park approval to do that. You're indicating what the mandatory services are, and therefore the MSAs can't stray from that, and the envelope funding that you're going to give is for those services. I think you should allow some freedom in this legislation, though, because again, contrary to the public pronouncements, I don't think there's much freedom in this legislation.

If you really want those creative juices and those timely responses to needs out there to come forward—because ministerial approval takes, what, an average of eight to 10 to 12 weeks, sometimes months to get a ministerial approval on a life-saving drug when someone's in crisis, for goodness' sake. I doubt MSA projects are going to be high on the minister's list of approvals when she or he already has too many things than one human being can possibly do during any given day. Certainly, with drugs or other things right now that require ministerial approval, the backlog is already too long.

I know how this actually works. The approval would be recommended by the local area, but of course unless later on you're designating and decentralizing the whole approval process for this reform, you will have to eventually wait for ministerial approval, which may be your plan. I see we don't have directors any more; we have

program supervisors. I doubt you're going to give them that sort of approval power, but I think you're going to have some trust in these MSA boards. I'd rather trust the MSA board in the local community to reflect its needs and respond to the needs in a timely manner than your own supervisors, bureaucrats or indeed the minister.

We're supportive of this amendment and think that if you're really serious about giving flexibility and responsiveness and the ability to respond to local communities, you've got to start giving on some of these amendments to ensure that that flexibility exists, *de facto*, in a community.

**Mrs O'Neill:** I think we have to remember here that we're talking about optional services. We're not talking about the mandatory basket. We know also that there are going to be over 100 MSAs. There likely will be somewhere between 100 and 300, depending on how the district health councils come down with their recommendations.

We're talking about services that may be funded by another ministry as well, particularly in children's mental health and housing. But I think the biggest thing is that the minister herself in the House yesterday was very adamant in saying that these were community-based endeavours, community-based boards, and in fact she was stronger on that than we expected, particularly when we started to talk about severance cheques.

But now we have this contradiction. You get a board and, let's face it, these boards are going to be duly elected. That's what we've been told anyway, and we've been told how they're going to be duly elected. They can't make a decision without an approval of somebody, and we don't all live in Toronto. The approval is hundreds, in some cases even thousands of miles from here. It comes, it goes.

1620

In the meantime, there has been a group of people on that board who are very keen on a certain project. They've seen a need in their community. They've got a kernel of an idea, they've got some corporate sponsorship and they've got some ownership of that idea. It's a good idea. It's supported by the medical community and maybe other social services communities in that particular area, but they can't do a thing until all the red tape that we know this bill is going to create has worked its way through. By that time, there may be another election on that board. By that time, that worthwhile project may be lost.

I've seen this happen, where good ideas, because of the red tape, just happen to end up on the cutting room floor, and I don't think it should happen here. There are so many regulations. There's so much prescriptive in this bill. Why don't we let the optional services be truly optional?

**Mr Wessenger:** First of all, I'd like to indicate that the intention is for the minister to delegate the approval process to the area offices basically, in most cases. Also, you might occasionally have a multiservice agency want to do something outside the area of long-term care, in which case I think you'd want to have some control over

the activity if the activity was outside the long-term-care area. For instance, if it wanted to operate something that let's just say is a correctional facility or something of that nature, you might have some hesitation in allowing it to go into services beyond the—or run a casino.

**Mrs Sullivan:** I'm quite taken aback with the facetiousness of the last remark. The multiservice agency boards are quite clearly limited in the authority they have in a number of ways: They're limited by funding approvals and transfers; they're limited by the fact that they are a representative board where the membership is prescribed by the law. I suggest to you that the purpose of the bill indeed is translated into the mission statement of the MSAs no matter how you cut it. To suggest that an MSA board is ever going to approve running off into the area of casino gambling or other such circumstances is absolute nonsense and irresponsible.

However, by law, the MSAs must provide the mandatory services, and the boards are accountable for the provision of those services. The only way those services cannot be provided is if the minister personally says that for X reason, when that reason is put forward by the board to the minister, those services may not have to be provided by the board. For the most part, there is a time exclusion surrounding that exemption.

I suggest to you there are many services which are not included in the mandatory basket that may well meet the population needs of the client group of the MSA. I think of podiatry services, I think of dental hygiene, I think of chaplaincy and spiritual services, psychogeriatric groups and counselling, prevention and promotion programs that may well help those people who are living in the community to cope with the issues surrounding their own care and to become better informed.

By example, on the prevention and promotion issues, if an MSA board felt that it was appropriate to have a circulation program of videos with respect to foot care, with respect to dealing with some of the issues surrounding the approach of death, in my mind, without the minister's permission, it would be quite, quite appropriate for the MSA to take that action.

There are other circumstances where there are joint ventures with other agencies and organizations in a community. Many of them may be jointly funded by other ministries, whether it's the Ministry of Citizenship, the Ministry of Housing, the Ministry of Community and Social Services or other ministries, including the ministry of justice, which has to deal, by example, with the Substitute Decisions Act and consent-to-treatment bills, where there may well want to be a program that the MSAs put together on their own to ensure that their people receive services that are appropriate and that go beyond the minimum basket of services that we all support. In those cases, there ought to be no need or necessity for a multiservice agency board to seek the approval of the minister, or even of the so-called program supervisor, who's supposedly out there in the regional area, for the MSA to offer those services.

I suggest to you that if you are saying that every board of every multiservice agency, in order to take a decision that is beyond the minimum basket, must go running to

a program supervisor, you might as well not have the board in the first place, you might as well forget all about this community representation, and all the chat that we've heard about consumer representation is for naught. It doesn't mean a damn thing, because even if the consumers demand a service, even if they say they want it, they still have to have the imprimatur of the local program supervisor.

It makes absolutely no sense at all, and if Mrs Leitch and her consumer alliance understood the implications of this section of the bill, you can believe that she would have this place full of representatives and they would say, "Take this out of here."

**Mr O'Connor:** I've taken a look at this motion before us and have tried to follow and understand the rationale that my colleagues are presenting. Of course, this relates back to a previous section in the bill. In that list of areas of services that are recommended in the minimum basket, it includes things such as—and as presentations have been made, and recognizing some of the needs in the community—social or recreational services.

Now, it could be that an MSA would take a look at recreational services, and in a given community you may have a lawn bowling club, and you could then have the MSA, being part of the same group of people, wish to start to pull them together, thinking: "Well, all we're doing is complying with the legislation before us. It says that this is part of the minimum basket of services that we have before us."

The fact of the matter is, that's not the intention, that they take over, for example, the lawn bowling.

It makes sense, and in most cases I can see, where the local MSA starts to have a discussion about whether or not they should extend services into an area that maybe is beyond their mandate, they're going to go to the area office. They're going to go and talk to the people they've worked with.

**Mrs Sullivan:** Big Brother's watching.

**Mr O'Connor:** They're going to work with the area office and ask for advice and consultation. So all we're suggesting here by having this amendment in place is that you do have to. So if you're going to extend the services far beyond what is encompassed, then the reaction that is happening, it's a stretch.

I don't support the removal of this. Today there are more people asking for accountability in government spending, and all we're saying is that before the services are expanded, before they go beyond what is expected and what is reasonable, they talk to the people in the area office and have that consultation, make sure you're going in a direction that isn't stretching beyond your mandate.

It's unfortunate that my colleagues will play this to the worst degree. I don't doubt for a moment that the MSA is going to have a good level of cooperation between itself and the area office, that this will be the procedure followed. I don't support this Liberal motion trying to remove this. I believe it's something that will make for a good working policy by the people in the local MSA with the people in the area office.

**Mr Jim Wilson:** I appreciate the debate by Mr O'Connor, but the PCs' very able researcher, Ms Charis Kelso, LLB, has brought to my attention one of the groups that wanted this particular amendment, the Ontario Dental Hygienists' Association. I just want to read from page 8 of their brief that was presented before this committee. I don't have a date on the brief but we could always look it up. It says:

"In noting the absence of dental or dental hygiene care from the list of services which a multiservice agency shall provide, the Ontario Dental Hygienists' Association questions whether other valuable services have been omitted. Care of the feet is one that seems obvious."

"Subsection 12(2) states that services not mentioned in subsection (1) may be provided upon authorization of the minister. The ODHSA finds it incredible that a multiservice agency would have to seek ministerial authorization for something as basic to overall health as dental hygiene or foot care. The youth of this province are recipients of dental hygiene services and seniors should be as well. The DHCs, local communities and MSAs should be given more flexibility in determining what services are needed and provided."

1630

That's exactly the argument the opposition parties have tried to put forward. I think the government members are speaking out of both sides of their mouths when they say they're providing flexibility and then, when push comes to shove and an amendment is presented which allows flexibility, they go on the defensive, don't want to hear any new ideas, don't want to hear any reiteration of what witnesses told us, they're just absolutely in a bunker mentality when it comes to defending this legislation. That's unacceptable, and I'm beginning to wonder if the idea here in this committee isn't to just try and wear down the opposition so we'll give up.

**Mrs Sullivan:** Oh, there's a lot of life in us yet.

**Mr Jim Wilson:** But we're not going to give up, and at the rate things are going we're never going to get out of this committee, there aren't enough days between now and Christmas to get us out of this committee. We will redouble our efforts on this side to bring flexibility, common sense, telephone numbers and everything into this bill that you people say is part of this legislation but refuse to actually put in.

**Mrs Sullivan:** I just want to reiterate that it's very clear if the government does not concur and does not agree to remove this particular line of this subsection of the bill, it is providing evidence that even though it has a full mechanism for local community boards, it has no trust in those boards and that the authority which is granted under this section is a formal authority. What that means is that the board must take its recommendations by formal resolution, with a proposed description of the project. This will not be informal approval, as Mr O'Connor has suggested; this will be a formal seeking of the authority of the minister via her program supervisor, who may or may not be in the local community, by the way. It's clearly Big Brother overlooking the volunteers, the community members of the board, who are elected. It's an override on local decision-making.

If anybody out there wants to listen to any more rhetoric about how representative and how community-based and how community-run these MSAs are, they should just know they are dreaming in Technicolor, because there is nothing that these MSAs can do without the involvement of the bureaucrat who represents the minister. They're just window dressing. It's sheer window dressing to have community boards as long as this line is in this bill.

**Mrs Haslam:** Oh, that's ridiculous.

**Mrs Sullivan:** It is absolute window dressing.

**Mr O'Connor:** People expect accountability from the government. In fact, we saw a parade of documents that ended up being the Minister of Health's responsibility because they were sent out by people within the government bureaucracy—directly responsible for all these boxes. You would think she had signed the courier slip. That was what happened in question period.

When we talk about this envelope of funding that is a responsibility that we're passing down to the board of the MSA, we are saying, "We are giving you funding, we are giving you dollars, and we want you within your community to provide the services within this envelope."

**Mrs Sullivan:** It doesn't say "funding."

**Mr O'Connor:** "Here's a minimum basket of services," and what we are saying is, "Before you go and expand those services to beyond what we're suggesting here, there needs to be an accountability mechanism."

**Mr Tony Martin (Sault Ste Marie):** Absolutely. If that's the way you work, that's the way we're going to work.

**Mr O'Connor:** The responsibility of the MSA is to work with the consumers to make sure that the services are being provided to the consumers within their area. The government of the day is going to be responsible for the dollars being spent. I could imagine this in question period. It may seem like a bizarre circumstance, but say all of a sudden a local board decides it is going to take over lawn bowling; I use that as an example. If they went through to the ministry officials, they would say, "This isn't responsible and this isn't what is suggested as happening in this section of the legislation." We are putting in place an accountability mechanism and now the opposition is saying, "We don't need accountability mechanisms."

We want to empower the community to provide the services, but we're saying there's got to be some accountability.

**Mr Martin:** You can't have it both ways, folks. Either you want us to be accountable or you don't.

**Mr O'Connor:** There needs to be an accountability mechanism to this. I'm suggesting that this amendment takes away the accountability mechanisms that are necessary. Governments are accountable, and for us to have that accountability mechanism in place—

**Mrs Sullivan:** You just don't trust the boards you're supposedly setting up.

**Mr O'Connor:** I find it surprising. In fact, we've had amendments come before us that don't want to even see

the empowerment we're talking about here.

**Mrs Sullivan:** No one brought in an amendment like that. What are you talking about? Name names.

**Mr O'Connor:** They want to see the status quo continued. We're suggesting that while we want to empower the communities, at the same time, there is responsibility in being government. What we want to have in here is an accountability mechanism for government, which is something that is expected of government.

**Mr Martin:** Typical Liberal attitude.

**Mr O'Connor:** I wouldn't recommend to my colleagues that we support this. I appreciate where my colleagues are coming from, but I guess it's different when you don't have to worry about that accountability mechanism. We are. We're responsible to the taxpayers of the province. When we provide the funding envelope for the services, there has to be some accountability in there.

**Mrs O'Neill:** To hear the last speaker, you'd think the only person who's going to be responsible or accountable is the Minister of Health. I thought we were going to have duly elected boards from duly elected memberships and that these people were going to be accountable in their communities. That's what I thought we were setting up here, according to the NDP plan. But no, these people are not really going to be accountable. That's the problem. Only the minister is accountable.

**Mr O'Connor:** You don't like community empowerment. That's the problem.

**Mrs Sullivan:** We don't like the minister's empowerment.

**Mrs O'Neill:** I let you speak, Mr O'Connor. I don't expect to be interrupted by you.

**Mrs Haslam:** Oh, Barbara, did you hear that?

**Mrs O'Neill:** I was speaking to Mr O'Connor.

**Mr O'Connor:** A point of order, Mr Chair.

**Mrs Sullivan:** No, you have no point of order.

**Mr O'Connor:** I want to apologize to Ms O'Neill. I apologize for interrupting her during her opportunity and apologize for disturbing her train of thought. Yes, her colleagues might interrupt us, but she doesn't.

**Mrs O'Neill:** The "may provide" here is again permissive. We're talking about permissive and we're talking about optional. We're talking about the provision of a service and "arrange the provision of a service." "Arrange the provision of a service" usually means partnerships. You know, things happen naturally in communities: Partnerships are set up. So we have an unequal body, the MSA, making a partnership with, if you want to call it a municipal council or a school board or a community association. They don't have to go to anybody else to get the approval. These people have it vested in themselves to be part of a partnership for the benefit of their community.

1640

If you read many of the acts of this province, including the Education Act, even the provision of bus service to schools in this province is a "may." There are tons of "mays" in the province's legislation. All of a sudden, we

have a "may" on provisional services, optional services, and we're told it's got to go right to the minister. This decision cannot be made by a duly elected board, even though there may be no funding attached.

This bill says nothing about funding. It doesn't say that if the service is approved it will be funded by the ministry. This part of the bill seems to talk about arranging and developing partnerships and integration and all the things this bill is supposed to do. That's why this is so difficult for us to understand, that we can't give this board any authority at all.

**The Acting Chair:** I have no further speakers. Is there any further debate?

**Mrs Sullivan:** Recorded vote.

**The Acting Chair:** All right, we'll have a recorded vote. All those in favour of the motion?

**Ayes**

Jackson, O'Neill (Ottawa-Rideau), Sullivan.

**The Acting Chair:** All opposed?

**Nays**

Carter, Haslam, Martin, O'Connor, Wessenger.

**The Acting Chair:** The motion is lost.

**Mrs O'Neill:** Shame, shame.

**Mr Cameron Jackson (Burlington South):** "I move that section 12 of the bill be amended by adding the following subsection:

"Volunteers

"(3) A multiservice agency shall develop and implement a plan for recruiting and using volunteers to recognize and help further the role of volunteers in the provision of community services."

Much has been said about what may or may not happen with respect to the continued utilization of one of the largest human resources sectors contributing to health for seniors, that is, a whole host of volunteer positions, groups I will mention in a moment, but they are well known to every member of this committee. The concern we have is that the speculation will continue if we do not have somewhere enconced in this legislation not only a reference but a direction to an MSA that it shall undertake to coordinate these activities.

I understand and appreciate that a few days ago we included in the purpose section of the bill scant reference to volunteers, sort of like a "Wouldn't it be nice?" clause. What the Tories are suggesting by the amendment is just in the same way that organizations such as Saint Elizabeth homemaker services, the Red Cross, any number of organizations, currently have a program in place which coordinates the activities of volunteers.

As we know, the unions, the handful or very few which came forward to endorse this legislation so fully, had a major caveat concerning the reduced reliance on and support for volunteer positions in this sector. For that reason, we feel the government could proceed along those lines in the absence of stronger direction in the legislation, which we believe this section gives.

I'll give a couple of examples. What happens is that because you have volunteers, you develop your own

program to recruit and train them, you have a program to sustain some of their incidental expenses, and you budget accordingly, and you have a series of appreciation nights, awards, all manner of activity which acknowledges publicly the outstanding work they do. I daresay that in the annual reports of these organizations, this volunteer component is somehow quantified: thousands of person-hours of volunteering, the saving that accrues to the delivery of service, or, put another way, the ability to extend services to more and more seniors by virtue of the recognition and utilization of volunteer services.

We are very fearful that it is possible, the way the current legislation is going—there is this huge assumption that the volunteer sector will just move right in and all of a sudden have a clearly defined role. I'm suggesting that cannot happen and will not happen unless we find room for reference to it within the legislation.

If we recall some of the clear and cogent arguments that were presented by all manner of groups—the first one that comes to my mind is very, very close to home as the Sisters of St Joseph helped bring all 10 of my brothers and sisters into the world. I always take occasions like this to say thank you to the Sisters of St Joseph. They made several presentations, and one which was a very memorable one for me in Hamilton. I'll quote very briefly, in the interest of time, Sister Joan O'Sullivan from her brief:

"We have grave concerns, however, that this legislation as it is currently proposed will effectively eliminate the contribution of volunteers and staff who have developed programs and services for seniors in response to identified community needs. We also submit that a shift in governance and administration to a government-controlled bureaucracy, the MSA, will not necessarily be cost-effective nor more responsive to community needs. It is unrealistic to think that one can dismantle a system which has been in place for so many years and reassemble it under a new governance and administrative structure. Health care is not conducive to a cut-and-paste approach to delivery.

"There is also the critical element of choice for seniors missing from this proposed structure. For example, if seniors do not feel they are receiving adequate or appropriate care through the MSA, are they at liberty to seek help elsewhere? Will it be available, and at what cost? These are the real issues which seniors are expressing to us, related to this proposed legislation."

That is what the Sisters of St Joseph had to say. They were expressing considerable concern about the whole issue of the contribution of volunteer staff, of the programs specifically developed for them; that they provide a certain level of service as a result of having programs in place. That's why the language in our recommendation is very, very specific.

I also want to indicate that we have heard from many groups who have indicated that they will not stop volunteering as a result of now volunteering for an agency of government. It's quite extraordinary. I mean, you don't see people going down to volunteer to be pickup drivers for the local licence bureau when they're paying \$75 to get a licence in this province, and you don't see people

offering to drive people to go to the assessment office to pay their property taxes. But there are some who may still want to go and help a government agency because of this human element of service which the government agencies will be providing.

There are many, however, who have indicated that they will switch their volunteer support to some other component of the health delivery system. Just as Red Cross might be cut out of or eliminated from home care in a given community, Red Cross will provide additional services, and so those volunteers, instead of doing Meals on Wheels or whatever, will do other work within the Red Cross.

I had one family call me just last week as a result of watching this on television. They gave me permission to mention their names: Tom and Gerry Clarke of Burlington, Ontario. Ten years they've been driving for Meals on Wheels. They have built up tremendous relationships with their clients and their friends, they've made friends of these seniors they visit, and they want to continue with the continuity.

#### 1650

But when you look from the volunteer's perspective at what level of appreciation will occur, what level of recognition for their out-of-pocket costs, what recognition for their liability when they're out driving on behalf of these organizations, they have indicated to me that they've already approached two other charitable organizations they feel they would be comfortable providing their services to.

Both, incidentally, are seniors-oriented, but they feel in all conscience that if the government is going to take over this service, they pay enough taxes for that and there are many, many other occasions in the community where their volunteer support could be used and appreciated and, frankly, is very desperately needed in some areas.

They are typical of a lot of people who will simply say, "Look, that's why I pay my taxes." Therefore, the government is setting out that it wants to provide this service with a civil servant. They have every right to do that. What we're asking in this clause is that if your MSA is directed to develop specific programs for volunteers, then hopefully we'll get people to come and volunteer for the government agency.

Clearly, if to the extent that the stories we've heard from the province of Quebec are true, then in fact it would be a proactive move on the part of the government to develop a plan which anticipates some dropoff of volunteers in the front end of the implementation of this legislation. If MSAs are so busy developing their other aspects of their operation, it's clear that they wouldn't put much of a priority on volunteers if they're not directed specifically to do that within the legislation. These people will naturally drift into and work for and volunteer to a whole host of other agencies simply because the MSA didn't bother to pick up the phone and call them. That's part of the reason.

Last week I made reference to Senior Link, which is an outstanding organization which will be gutted by this legislation. But if you take the time to go and look at this

program—and a few members in the opposition side have visited the program—you will know that every time you met a client you also met a volunteer. This permeated the entire approach that Senior Link was operating with. Therefore, their cost of administration dropped substantially per client served, plus they were able to provide a basket of services to an average senior whom they were in outreach to in the Danforth, which is, for people who are watching, a section of Toronto.

Given the fact that the government has already indicated through the amendments to this bill that an organization like Senior Link will not be allowed to be an MSA, which is unfortunate because I understand there's going to be at least one MSA for the Danforth area that this organization serves, I would like to circulate this in the hope that members will have a look at it.

Every day of the week it gives a different volunteer doing a different job, doing a different service and providing human contact directly with not nameless, faceless seniors who need services, but people who need that touch, that continuing touch and interaction with real people. Just because the homemaker may be in your apartment for 20 minutes and then you don't see that individual until three days later, the role of volunteers is to really augment and support those interventions, which are far too infrequent and do not sustain the kind of contact that the average senior needs when living alone.

On Monday, for example, they have a case worker, and the volunteer is Ethel Day. On Friday they have Jayne Walkom, who's a volunteer meeting with a resident named Alice at Stephenson House. These are real people. That is why we are hoping that this legislation will include a reference to volunteers.

I'll yield the floor in a moment so that other members can have an opportunity. I'm sure the government is anxious. They have been reassuring us that they believe that the volunteer sector will stay and will participate and get involved. This is really the first opportunity to put in the legislation that part of the role of an MSA is to develop and have ready these programs in support of and in recognition of volunteers and to utilize, quite frankly, we're told, the hundreds and hundreds of thousands of person-hours of volunteering in this sector. This is one way of preserving that.

I'm anxious to hear if the government will take this occasion to put it in legislation or leave it simply to the purpose, which is not binding, which is just basically an overview statement as to where the government hopes or thinks the legislation might lead it. In no way does it tie the hands of an MSA so that it is obligated under law to ensure that these programs are in place.

**Mr Wessinger:** I'd like to point out that we will be moving an amendment to the bill, section 14.1, which addresses the whole question of requiring a multiservice agency to "develop and implement a plan for using the services of volunteers in the provision of community services by the agency and for recruiting, training, supervising, retaining and recognizing such volunteers."

I prefer our approach because it will set out a separate section. It will be in its own separate section, this requirement to establish a volunteer plan. I think that highlights

it more than adding it to another section. So I'd suggest we proceed on that basis.

**Ms Jenny Carter (Peterborough):** As Mr Jackson pointed out, this has been a main object of concern by presenters. But I think it was always the intention of the bill that volunteers would stay with it. As the parliamentary assistant has pointed out, this point is more than covered in section 14.1. I understand that it is in fact stronger in that position than it would be if it was in section 12, because it's now a core function and it's very definite, very positive.

I would point out that by involving volunteers in the boards that will run the MSAs, in other words, by having volunteers as part of governance, we are now extending the function of volunteers from the position that they previously held to being part of governance as well. Of course, a third of those boards must be consumers and informal caregivers. So they're obviously going to be people from the community without other interests.

In any case it seems to me that this bill is going to strengthen the function of volunteers. The local planning which is going on already in most areas, led by district health councils, is again a volunteer function, because there are volunteers on those district health councils. The transitional period of four years that is being allowed in this legislation will allow for a gradual coming together so that there's no point at which the volunteers would be, as it were, expected to fall away, and there will be locally created and managed volunteer recruitment and retention strategies.

There is a series of forums taking place, cosponsored by the Ministry of Health and the Association of District Health Councils of Ontario and the United Way of Ontario, that will examine volunteer recruitment, retention and fund-raising in the new system. So that is being looked into.

I think it's worth mentioning in this context that we've been told that somehow the new agencies will be impersonal, they will not attract volunteers. There's no evidence from what we can see in the current state of affairs that government-run agencies do not attract volunteers, for example, hospitals do retain volunteers although they are frequently quite large and bureaucratic structures.

**1700**

The VON, the Red Cross and the Saint Elizabeth nurses of course are big agencies themselves, and what we're looking at is something smaller, more grass-roots. So to see this as moving somehow into the impersonal and the vast is perhaps looking at it the wrong way up.

Volunteers are attached to their role in their own community just as they're attached to the agency for which they happen to be working and through which they express their commitment.

Certainly, when I look for example at Meals on Wheels in my area, that's what it is, Meals on Wheels. It was created on the spot, as it were. It's almost 100% volunteers. It seems to me that as the MSA develops, there is no reason why the structure and the location of an agency like that would change. It will come under the jurisdiction of the MSA, but the storefront offices, for

example, there's no reason why those things would change.

Another point that has been made before but I think is worth noting is that where community support agencies have voluntarily amalgamated, such as in Durham Region Community Care, Victoria County Community Care, which presented to us, and community support providers in Haldimand-Norfolk, the volunteers have remained with those agencies. In fact the volunteer base has increased. So I think we've more than covered this whole issue.

**Mr Jim Wilson:** I don't particularly understand the government's reasoning in saying that by including volunteers in an added section in 14, that would provide greater strength to ensuring that the objectives of the PC motion respecting volunteers are met. It seems to me 14 deals with information and referral and is a much weaker section to have a volunteer section following it than section 12 here, which talks about "a multiservice agency shall provide or ensure...the following services in the geographic area for which the agency is designated." It seems to me that this would be a more appropriate section to ensure that the strength and intent of this amendment are fulfilled.

Perhaps legal counsel would like to give us an opinion on that.

**Mr Wessinger:** We think the language is much better in section 14.1 than in the amendment moved, and for that reason we prefer our language over the language that's set out in the Conservative motion. We think it's a lot stronger and also we think the volunteer plan should be together with those sections that relate to what the obligations of a multiservice agency are. Section 14 is where we feel—although it wouldn't be in 14. It would be a separate section, because 14.1 would end up being renumbered probably 15, 16 or 17, whatever it happens to end up when we subsequently reprint the bill. But we feel it belongs in closer proximity to section 14.

**Mr Jim Wilson:** That's fine. I appreciate the explanation.

**The Acting Chair:** Is there any further debate? All those in favour of the motion?

**Mr Jim Wilson:** Can we have a recorded vote?

**The Acting Chair:** Recorded vote. All in favour?

**Ayes**

Jackson, Wilson (Simcoe West).

**The Acting Chair:** All opposed?

**Nays**

Carter, Haslam, Malkowski, Martin, O'Connor, O'Neill (Ottawa-Rideau), Sullivan, Wessinger.

**The Acting Chair:** The motion is lost. I believe that concludes the motions connected with section 12.

**Mrs Sullivan:** Mr Chair, are there any amendments with respect to first nations for section 12?

**The Acting Chair:** Not that we have received. I will put the question with respect to section 12 as amended. All those in favour? All opposed? The motion is carried.

Moving on to section 13. The first motion I have before me is a Liberal motion.

**Mrs Sullivan:** Mr Chairman, the clerk is just now distributing a replacement motion, just so there will be no misunderstanding about the words. I've just rewritten it.

I move that clauses 13(2) and (3) of the bill be struck out and the following substituted:

"13(2) A multiservice agency shall determine from time to time the optimum mix of community services which it may provide directly and the amount of community services which it may purchase from other service providers.

"(3) A multiservice agency may purchase a community service from another multiservice agency, a service provider, an individual or a person."

**The Acting Chair:** Excuse me, Ms Sullivan.

**Mrs Haslam:** Mr Chair, isn't that a different motion? Isn't that a different amendment?

**The Acting Chair:** No, I'm informed that there are other motions that will proceed prior to yours. Ms Sullivan, if we could.

**Mrs Haslam:** Mr Chair, she's read—

**Mrs Sullivan:** Which one would be first?

**Mrs Haslam:** She's read the other one, whereas the first one I have in mine is Alt-2, Liberal motion.

**Mrs Sullivan:** The one to the entire bill?

**Mrs Haslam:** Excuse me, Ms Sullivan. I'm just asking for clarification too.

**The Acting Chair:** Can I have a moment, please?

**Mrs Sullivan:** I suppose the question is which comes first, section 13 or subsections 13(2) and (3).

**Mrs Haslam:** In the order that I have in front of me, I have section 13 and you read 13(2).

**Mrs Sullivan:** It's his ruling. He has to decide.

**The Acting Chair:** It's Alt-2.

**Mrs Haslam:** Alt-2? Yes, you read Alt-2.

**The Acting Chair:** We should be proceeding with section 13.

**Mrs Sullivan:** All right. Thank you. I will do that then.

I move that section 13 of the bill be struck out and the following substituted:

"Purchased services

"13. A multiservice agency may purchase as many community services from other service providers as, in the opinion of the multiservice agency, are necessary in order to ensure that the needs of the community in the geographic area for which the agency is designated are met."

This amendment is put forward to ensure that a multiservice agency is not limited by the current government's approach to the 80-20 rule, indicating that the agency is limited in the number of services it can provide or is limited in the number of services which it may purchase from outside of the agency.

Our view is that particular requirement will mean that agencies will be left in a position where they will be unable to meet the needs of the community, the communities themselves will be left in positions where it's

automatic that—are you having trouble with the amendment?

**The Acting Chair:** No, that's fine.

1710

**Mr Jim Wilson:** On a point of order, Mr Chairman: Would this amendment be out of order since it deletes the entire section and would run contrary to the purpose of the act? I happen to agree with it, but I just wonder if it's out of order.

**Mrs Sullivan:** No, it's quite in order.

**Mr Jim Wilson:** I recall trying this a couple of times and being ruled out of order.

**Mrs Sullivan:** You just didn't do it right.

**Mr Jim Wilson:** You'll note, Mr Chairman, that there's a very good PC motion coming up which has the same effect that's probably in order.

**The Acting Chair:** I'm sure there is. I'm just waiting for the advice of my learned advisers here.

It's not out of order.

**Mrs Sullivan:** Good. Thank you.

**The Acting Chair:** Please proceed.

**Mrs Sullivan:** As I've indicated, one of the issues that has been a matter of concern everywhere in this province that the public hearings were conducted in and throughout the entire process is that groups, organizations and facilities which have provided exemplary community services will be eliminated from the provision of long-term care and from involvement in long-term care as a result of this 80-20 rule. The 80% that the MSA must provide is a significant proportion of services, and it means that the operations of other community-based agencies will be completely skewed.

There are a couple of issues that become more and more important as this moves on. Let me suggest to you that the Victorian Order of Nurses, for example, has emphasized the specialty care of in-home renal dialysis patients. That care is subsidized through other work of the VON. The other work of the VON includes other home nursing care that's provided by the VON, and without the critical mass of services that are included in the publicly funded community-based portion of their work, it will be impossible for the VON to continue the specialty work it has been doing in home renal dialysis. Without that specialty work, we will not have home dialysis, and those people who are concerned with end-stage renal disease ought to be very, very concerned about that issue.

We know that the pressures on funding of support for people with kidney illness and disease is very high. We know that virtually every community in Ontario is now under pressure for those kinds of services. We know that one of the alternatives that has proven in many circumstances to be cost-effective is the community-based dialysis clinic or the home clinic, and we know that the Victorian Order of Nurses has placed a considerable effort and expertise into ensuring that the specialized nursing care that's required, whether it's self-care or whether it's assisted care in the home or in the community, is available.

The truth is that the critical mass of work for the Victorian Order of Nurses will no longer be available with this 20% rule, and what that means is that the Victorian Order of Nurses will not be able to sustain these specialized dialysis services they are now providing.

I emphasize that one area because it's one that's quite significant in many parts of Ontario now because the services are already so strained. Even with initiatives at the Sutton centre, the pressure on community-based dialysis continues at the same rate as it was because of course the incidence of renal disease is increasing.

Without an amendment of this nature, we believe very strongly that children's services will be extraordinarily affected, that there will not be an opportunity for the multiservice agency to continue using the specialized services that have been developed particularly for children, whether they are children's treatment centres or whether they are other services that are unique in their development and in their provision through other specialized care deliverers in various communities.

In many instances those services are too few and too far between. I think, by example, of speech pathology as being one area where, even if it's included as a mandatory service, which it is, the services are not available, the trained people are not available, the school boards are moving out of the services and it's highly problematic to assume that the MSA will be able to provide those services on its own. Furthermore, where those services are available, they may be linked to another agency. What you're saying is that even in crisis situations, the agency will not be able to provide those services.

We spoke earlier about dental hygiene, we spoke about podiatry, chiropody and other services which may in fact be an absolutely vital part of a person's personal care plan. Within the 20%, any service that's not included in the mandatory basket must be purchased out of that 20% budgetary item. What this says is that there is no guarantee that those services will be available, particularly if the 20% limit or cap has been superseded. Because the specialized services also must come out of the 20%, once again that provides additional and further pressure on services that can be provided by agencies such as VON, St Elizabeth Visiting Nurses' Association and even Red Cross homemaking.

I suggest to you that the work of those agencies, which have been community-based, which have been volunteer, which have been very involved in a private, if you like, or public volunteer agency consortium, will now become bases for the practice of private medicine. I believe this 20% rule is a major first step on the way to a two-tier system. In fact the march to the two-tier system will be significantly enhanced unless the government moves on the 80-20 rule.

**Mr Jim Wilson:** I appreciate Mrs Sullivan's comments on the 80-20 rule. You'll recall we visited this issue earlier when I presented the PC's federated model. That would have abolished the 80-20 rule.

I guess what disturbs me most is that throughout long-term-care reform, throughout the discussions that we had across this province—the government takes great pride in having consulted with some 75,000 citizens and residents

of this province before drafting this legislation and we were told time and time again that those citizens wanted this 80-20 rule, not only wanted coordinated service and one-stop access and coordinated assessment, a common assessment tool, a phone number to phone—basically they were asking government, I think, to keep the current players in the system but to make it easier to access those service providers, those players in the system.

1720

With the exception of the senior citizens' consumer alliance, I think all of the other groups—because at one time during the hearings, I remember, the Ontario Community Support Association was also quoted by government officials as being another group that was in support of the 80-20 rule. Since that time, really what we've discovered is that there's one group and the NDP out there that think the 80-20 rule is absolutely essential to the future delivery of long-term-care services, community services in this province, and nobody else. I think well over 95% or 96% of the presenters who appeared before this committee argued against this.

Something historic has happened at this committee, and that is that while during the discussions on Bill 101 we had quite a bit of private-sector-bashing going on and we had the not-for-profit versus the private or commercial sector argument going on in this very room and in the Legislature when the government was bringing in its 10% rule, over the past year since the Bill 101 hearings and debate, there's been a unified voice coming from the not-for-profit providers like the VON, the Red Cross, the Catholic Health Association of Ontario and Villa Colombo. All kinds of not-for-profit agencies and associations that represent those agencies have actually joined together with the private sector to plead with the government to eliminate the 80-20 rule from this legislation.

I find it equally disturbing that there hasn't been a very good argument put forward for the need for the 80-20 rule. Why the government should have taken it upon itself to create a monopoly in the delivery of service is something that I don't think has been presented in a logical and understandable fashion to this committee. Therefore, it lingers as an ideological preference, it lingers as something that the NDP just wants to do and it raises questions as to what the true agenda is here.

I note in one letter, and it's Dr Michael Rachlis's colleague, who is Carol Kushner—to be fair, they are the only group other than the two I've mentioned, the NDP and its union friends the seniors' coalition, which I find is not, on this particular issue, representative of the seniors whom I've talked to or the ones who presented to this committee. Carol Kushner wrote us a letter within the last 10 days and indicated that it was absolutely crucial to long-term-care reform that MSAs have a monopoly on the delivery of service. Recalling her letter from memory, there wasn't a persuasive argument contained in there.

It makes one wonder, when you're going to make such a radical change, and this being the most radical change we've yet seen in the whole history of reform of long-term-care services, you'd think the government would have some sort of an argument you could sink your teeth

into and at least debate with respect to the 80-20 rule. Yet they don't appear to have one. They simply dismiss all of these groups. As I said, I'd say over 96% of the groups before this committee, and all the written presentations we've had, they simply just dismiss out of hand as either not knowing what they're talking about or they don't seem to understand what the government is trying to achieve or whatever.

Overwhelmingly, the people of this province are becoming to understand this legislation and understand that the 80-20 rule is the most important part of this legislation. If the government really wanted its reforms to succeed and really cared for and wanted to ensure that the needs and wants of seniors, the disabled and others who are affected by this legislation are met, they would abolish the 80-20 rule. What have we heard about it?

We've heard from people like Delores Lawrence of the African Canadian Entrepreneurs. Delores is president of that group. Delores, as I recall, started many years ago as a homemaker herself, and as an entrepreneur and a new Canadian, she's a tremendous success story now. She's built up a very large business that overwhelmingly employs women of minority status. She is providing private sector home care services being delivered in people's homes and is a success story. Unfortunately, she testified before this committee that she will be wiped out by the 80-20 rule, and for no good reason.

I recall very well her presentation. She just couldn't understand why the government has this ideological bent towards the private sector, especially when you consider this: When a service is performed either by the not-for-profit sector or the private sector in this province, the government pays the same flat rate. We even had a couple of presentations from private sector providers indicate that actually they even get a smaller service fee for some of the services in some parts of the province than their not-for-profit competitors.

Certainly, the Conservative government for many, many years allowed a mix to occur in the system, and that was between not-for-profit providers and for-profit or commercial agencies. There evolved, according to market forces, a mix in the system, and the people of Ontario for the most part were served very well. As I said in the Legislature yesterday in my question to the Minister of Health, we agree with the principles of long-term-care reform and we agree that some things need fixing out there. Where we disagree vehemently is on this 80-20 rule.

Those private sector providers have joined with many, many other groups. I just want to list those groups, because we've often referred to the ad hoc coalition that's been formed to fight the government on this legislation and I think it's important that we keep in mind who's out there telling the government it's wrong and that it's particularly wrong on the 80-20 rule.

It's the Association of Ontario Physicians and Dentists in Public Service, the Canadian Red Cross Society, the Catholic Health Association of Ontario, the Catholic Women's League of Canada, the Council on Aging for Ottawa-Carleton, the Federation of Provincial Non-Profit Organizations Working with Seniors, the Ontario Associ-

ation of Medical Laboratories, the Ontario Association of Non-Profit Homes and Services for Seniors, the Ontario Association of Residents' Councils, the Ontario Community Support Association, the Ontario Home Care Programs Association, the Ontario Home Health Care Providers' Association, the Ontario Home Respiratory Services Association, the Ontario Hospital Association, the Ontario Medical Association, the Ontario Nursing Home Association, the Saint Elizabeth Visiting Nurses' Association of Ontario, the Victorian Order of Nurses, Villa Charities, Ontario Home Care Case Managers' Association, the Association of Ontario Home Care Therapists and Ontario Home Care Medical Advisors. That was the list as of October 25. I understand there might have been one or two join since then.

That reads very much like a Who's Who in the delivery of health care services in our province, and these people are all telling the government that it's wrong. For reasons that have yet to be fully explained, the government isn't listening to these people, nor is it truly listening to the vast majority of those 75,000 people who participated in the consultations in the run-up to the development of this legislation.

I think that for future governments certainly one of their first orders of business will be to abolish the 80-20 rule, and I don't think this government has a mandate. It doesn't have a mandate from the providers, and I don't think it has a mandate from the vast majority of consumers. I would hope that even the one seniors' association that's supporting the government on this, if it remembers it's also the 80-20 rule that will drive away volunteers, that it's an integral part of the arguments we've made earlier about volunteerism—those same seniors, over the years I've been around, have generally told us they don't like monopolies. Jeez, they used to rail about Bell Canada having a monopoly and cable companies having a monopoly. Those are the two biggies that always come to mind, and we get lots of letters every year about those things. Generally, people are distrustful of monopolies. They think they're inefficient, and they are inefficient because there's no reason to be efficient.

1730

Also, I think not only are commercial providers necessary in the system and we shouldn't be wiping them out, but there's a healthy competition in the marketplace among the non-profit providers. They know they have to work together, that there are limited resources in the areas of the province they serve. They've been doing that, and now you're bringing this 80-20 rule in and putting them all out of business. It's not only the ultimate insult, but it's also the huge spike that seals the coffin for these providers.

The business argument is one the government doesn't seem to understand. For some reason, and I think it's extremely naïve, the government believes that it can have its cake and eat it too, that it can impose this 80-20 rule and say the MSA must deliver 80% of the services, with very limited exceptions, and that 20% of the market will be left for existing agencies.

As we said earlier, it doesn't make sense, when the market that's left over after the MSA is put in place is so

small, for these other agencies to even try to stay in the service delivery business for community-based, long-term-care services because they'd have to keep administrative structures around to serve such a small portion of the market that it wouldn't be cost-effective. That's the argument they're making to us, and for some reason the government dismisses that argument and still tries to tell the people of Ontario that it's not dissolving the VON or the Red Cross or private providers.

The private providers, by the way, currently provide just under half of the homemaking services in the province, so I can't understand how even the government, through the MSA model and the 80-20 rule, will, without an infusion of millions and millions of dollars, begin to fill the gaps that will be created as you drive the current providers out of the system.

That leads me to a very important matter that is most disturbing, and that is the government's absolute refusal to bring forward any type of cost-benefit analysis. Here you have the most important piece of long-term-care legislation to hit this Legislature in a great many years and they won't even provide a cost-benefit analysis. Oh yes, they did pay the senior citizens' consumer alliance to produce a Price Waterhouse study which, since its introduction, has been discredited by a number of groups mainly because it doesn't take a rocket scientist to figure out that its assumptions are faulty. Other consultants have come forward and put shame on and discredited the Price Waterhouse study.

When the groups were asked subsequently to produce their overhead costs, we found out that contrary to the mythology the government's been trying to spread as part of its rather fragile reasoning for the 80-20 rule, that the overhead costs, the administrative costs of the Red Cross, VON and Metropolitan Toronto home care services are really high—contrary to that, when we actually ask for those costs we find out that indeed they're already meeting what the Price Waterhouse study established as a target, and that's about 16% of overall budget going to administrative costs. A real, honest examination of the books of these non-profit agencies, and certainly the private sector agencies, shows they're already meeting that goal or doing better.

I want to read from my local paper a very good, short article put out by the VON:

"Study Outlining Savings Inaccurate, Says VON."

"The Victorian Order of Nurses (VON), who provide 97% of the in-home nursing services in Simcoe county, have expressed grave concerns over data contained in a report prepared by Price Waterhouse and released by the Seniors Alliance.

"The report claims that \$90 million could be saved in administration costs if long-established agencies such as VON, Red Cross and Saint Elizabeth Visiting Nurses' Association were closed down in favour of a government-mandated multiservice agency (MSA).

"'VON is supportive of the government's initiatives of long-term-care reform and a coordinated model that provides one-stop shopping for users of in-home services as efficiently as possible,' says Melody Miles, executive

director of the Simcoe county branch of VON.

"Miles went on to say, however, that VON 'is unwilling to see the system built on inaccurate and misleading data which will undermine competent planning of the system.'

"Many of the clients we care for in Simcoe county are vulnerable,' said Susan Wiese, president of VON's volunteer board of directors"—volunteer board of directors. "'In our haste to move to a redesigned service under an MSA model, we must take care not to lose the quality home nursing system that has served the people of Simcoe county well for 71 years.'"

You know, all the groups opposing the government, which is just about everybody in Ontario but a few people—and I will later continue to read from brief after brief after brief of people's arguments put forward to oppose 80-20—make sense.

I tried to step back from this during the clause-by-clause considerations when we were first introducing the federated model. I remember thinking the night before, "Let's try and take an objective view of this," because I don't like being broadsided in debate. "What in the world could the government's reasoning be? What sort of really cogent argument could they possibly make?" Frankly, you can't make one, and that's why they're not making one. You'd have to create one *ex nihilo*, out of nothing, you know?

**Mr Martin:** Get in touch with your own political philosophy.

**Mr Jim Wilson:** One of the members says, "Get in touch with your own political philosophy." I think we don't need a philosophy in this area. Why don't we just lay off government and not have a philosophy and let the service providers out there provide the services they've been providing so well long before government ever heard of long-term-care services, as I said yesterday, long before the NDP ever got its paws on the long-term-care services in this—

**Ms Carter:** For 10 years people have been looking for reform.

**Mr Jim Wilson:** Yeah, yeah, yeah, we hear people have wanted reform for 10 years. But just because people have wanted reform for 10 years—first of all, nobody asked for the 80-20 rule. I've been around as long or longer than most of you people. Nobody asked for this. I don't know how many times we can say it.

**Mrs Sullivan:** And you will be around longer too—overnight guests over there.

**Mr Jim Wilson:** Even those who truly understand it, who might've thought it was a good idea because it advanced the agenda of long-term-care reform, are now saying no to that. Just because somebody wanted long-term-care reform for a number of years is no excuse for the 80-20 rule. That's not an argument, because on the way to this bill, you didn't hear the need for the 80-20 rule.

I think it has more to do—and I read the other day from the Christian Labour Association—with unionization. Just around half of the employees in the community service sector now are non-unionized. Under our

labour laws, if you put all these people under one roof, which is why government needs its 80-20 rule, to get them all under one roof and create that monopoly, if you have unionized workers in with non-unionized workers you simply go to the labour board and you file an application and, lo and behold, the whole shebang in Simcoe county or in Metro Toronto, everybody who wasn't unionized, is unionized, a fairly quick process.

I don't think, and the Christian Labour Association made this point, that you should be doing unionization drives for the unions. If you go back to your grass roots and your first principles, it is that unions existed to protect employees, to provide a level playing field, a better playing field between management and employees.

They must evolve naturally from grass roots, and government doesn't have a role to come along and unionize or un-unionize people. That is inherently an unfair approach to the whole philosophy of unionization. The Christian Labour Association pointed that out and said, "We think the government, in its 80-20 rule, is heading towards additional cost and less service, because money will be taken up on this nonsense of creating the monopoly."

1740

It's probably time the opposition parties really put their foot down on this and really decided to not deal with long-term-care reform until the government comes up with some sort of cost-benefit analysis on this. I don't know how I can justify to my constituents dealing with this bill in the Legislature if I really don't have a clue what the costs are going to be and what the true agenda is. To me that's just inherently bad government.

I'll yield the floor for a few minutes and give the government an opportunity to respond. I'll be looking for those cogent arguments on why they need the 80-20 rule. In summary, on the road to long-term-care reform, in the government's own documents, other than stating a preference for the not-for-profit sector, which Ms Lankin did on several occasions and in documents, we certainly didn't hear anything about this 80-20 rule, this need to confiscate and expropriate the services currently being provided: as I said, in Simcoe county, 97% by VON, on the homemaking side 100% by Red Cross, and the government just wants to destroy all that.

They think for some reason that government, or an MSA, regardless of the language of a "consumer board" or whatever language you use to mask this, that this new bureaucracy will somehow provide these services cheaper. If that's true, show us the data, a fairly simple request, or do a pilot project, which is something we've asked all the way along too. If you really are hell-bent on doing this, why don't you set aside one area of the province that's currently well served by the VON and Red Cross and do a pilot project, keep it out there for a couple of years, before you devote millions and millions of taxpayers' dollars to a system about which you have no idea whether it will or will not be better?

The evidence before this committee is that it won't be better, that it will destroy volunteerism. The United Way of Toronto has said that unless a number of conditions are met, it will not be sending its fund-raising dollars to

these new MSAs. You're replacing agencies in Toronto with probably up to 20 or more MSAs in Metropolitan Toronto. The Saint Elizabeth Visiting Nurses' Association of Ontario data, some data that were presented to us, show that that would be an additional cost in nursing staff costs alone of \$7 million. So far, everything I've seen that makes sense to me argues against the 80-20 rule, and we would really ask the government to either come clean on what the true agenda is here or to scrap 80-20. I think we could have some serious discussion about getting this bill through the House without the 80-20 rule in it.

**Mr Wessenger:** When we look at this issue, I think the first thing we have to remember is that this is a publicly funded system, the long-term-care system. The dollars that go into the system are provided by government. Even though some of the service is delivered by non-profit agencies and some commercial agencies, it's still a publicly funded system.

As a government we certainly have a responsibility to ensure the wise use of tax dollars, to ensure that the consumers receive the best service possible in a cost-effective manner. For that reason, we have chosen the integrated MSA model as a model for delivery of these services, and that's the overriding principle with respect to the delivery system for services. We believe a functionally integrated model will be much more effective in providing better service.

First of all, if I might indicate some of the reasons we say it will provide better service, it will provide a broad range of services through a single access point, and it will also allow greater flexibility for the service packages so they can be individually tailored to be responsive to consumer needs, more so than to have a number of separate service providers. I would also suggest that case management experience shows that case managers can work more effectively in an integrated model than in a brokerage model.

With respect to the whole question of consumers and communities, if you're going to have consumer empowerment and community empowerment, you have to have a model that provides for a community-elected board, and we also want to provide for that with the consumer involvement through the MSA. We have had a process which involves a community planning process with members of the community involved in developing the MSA model that best meets that community's needs.

So we have, first of all, the better service to the consumers. We have, secondly, the empowerment of consumers and communities in designing the model and in managing the model. We also see reduced administration in a new model, because as you reduce the number of agencies you're going to have administrative streamlining. It's quite simple: If you have one payroll department instead of 150 payroll departments, you're going to have a more effective delivery system.

It's pretty clear that the debate here is about which is the best model and the best way to deliver services. We believe the functionally integrated model is the best model, and I must point out that that's what consumers told us. Consumers told us they wanted the same agency

to assess their needs as deliver the service, that they want that functional integration.

The 80-20 is a mechanism, not a principle; the principle is having the functionally integrated model. The alternative model is a brokerage model, which we do not feel will achieve the effective service delivery and do not believe will provide the efficiencies. We believe it is not as good a model; it preserves the existing inefficiencies, the existing fragmentation in the system.

We believe in the functionally integrated model. I know the opposition believes in the brokerage model. That's where the difference in philosophy is.

**Mrs Sullivan:** Point of order, Mr Chair: The parliamentary assistant is misrepresenting the view of this party. Our view is that the community that is responsible for ensuring the services are in place should have the freedom and the flexibility to determine the most appropriate model so that all the other elements of long-term-care reform are in place and that people are cared for in the way they are entitled to be cared for.

**Mr Wessenger:** I agree. The Liberals have tried to stay on both sides of the issue between the integrated and the brokerage models.

**Mrs Sullivan:** Baloney, that it's on both sides of the issue. It's ensuring that the people in the communities have a say. You have overridden that with your determination that the minister must authorize every single step, although you pretend that the agency boards are going to have power. Believe me, they have no power at all.

**Mr Wessenger:** Anyway, we live in a world where we're restructuring. We're restructuring our government, we're restructuring our agencies. Business is restructuring, government is restructuring, social service agencies have to, all agencies have to restructure. We can't close our eyes, we can't bury our heads in the sand. We have to accept that there have to be changes for the better.

**Mrs O'Neill:** It's been quite interesting to this point, listening to this debate. The words I remember about this particular part of this bill are "authoritarian," "dictatorial," "monopolistic," and now we've got "volcanic restructuring."

The people who are working on the plans for implementation of Bill 173 are members of the district health councils. Many of these people are also now members of the coalition against Bill 173. This is the part of the bill that is most offensive to people who have a real knowledge of how long-term care has been provided in this province. They realize that it has been built on partnerships, sometimes with the private sector—and that seems to be okay in most people's minds—but most often with the not-for-profit sector. At this moment the partnerships are there, the municipalities are involved and indeed the guidelines that have already been established regarding purchase of service for various communities have not been able to be met. Municipalities came and told us that.

1750

I'd like to begin my remarks by quoting our regional chair, who I think presented an excellent, very succinct brief in Ottawa. He suggested that section 13 of Bill 173 places limits on purchase of service and has raised many

concerns. He uses the words "lack of competition," "creation of a monopoly" and "translated into less client choice," and that certainly is very fundamental to this. Indeed, as many of the previous speakers have stated, the costs may just increase. He expresses that by saying, "The effect on the clients is of major importance if organizations are forced to join the MSA"—and, let's face it, many of them will be forced to join the MSA; they're not going to do this voluntarily—"and energies are directed to conflict resolution as opposed to service delivery."

I've mentioned before in this committee that I've had some experience in that. It doesn't happen well when it's forced and imposed. It happens well when people come together in a community to see how best they can form partnerships, provide services and do it in an economical manner.

Mr Clark goes on to say: "...the 20% rule will remain and will not necessarily reflect the needs of different communities."

"We believe that the determination of the purchase-of-service limit must be made by each community," and that certainly is our amendment.

Then, if I come to the Toronto scene, and we all know Villa Colombo, the expression of that particularly duly respected and indeed responsible group of people is: "By tearing down everything to get there doesn't make sense. A lot of people are very bitter. The communities that have created the services are being told they've done a lousy job."

Then, if we go to the VON, they very succinctly say, "The VON, as noted above, believes the MSA must have the independence to respond to local community needs, priorities and preferences through the most cost-effective and quality-producing methods of delivery. Thus, the VON is proposing the elimination on the contracting of services."

I just end my remarks, as I know the day is closing and others want to speak, by stating, as I find the county of Renfrew has so well expressed, the feelings of many regarding these hearings: "...the government has absolutely no intention of making any significant changes to Bill 173 in light of the province-wide consultation process. Surely, this makes the time and effort of the standing committee hearing process nothing short of farcical."

Unfortunately, that's the opinion of many people in this province, and this particular section of the bill is the one that is most offensive because it does not respect existing relationships; it does not accept or respect existing economies of scale—no cost analysis; no cost-benefit analysis; only one study that, as we know, has very questionable assumptions.

**Mr O'Connor:** I appreciate some of the concerns as raised. I must say that I disagree with a huge chunk of them. When the consumers' alliance presented its report, for example—and I know my colleagues disagree with that, and we've had presentations and have heard from agencies that disagree with that, and they themselves say, "Well, our agency only has an overhead cost, for example, of 15%, 16%."

What needs to be taken into account is the fact that there are many layers in the delivery of that service today. In fact, what we have in a majority of cases is a brokerage model, a very fragmented one, but yet a brokerage model. We have, for example, home care sometimes being provided, sometimes a level of administration happening at a regional or county level and then being sent out further to some of the other agencies within the community and another level of administration. All of that does need to be talked about as it is all part of why it's necessary. My opposition colleague Mr Wilson mentioned a letter from Carol Kushner and I'd like to read from it just a wee bit.

"Why the 20% rule is absolutely essential: People are used to home care buying community long-term-care services on their behalf. Earlier proposals in long-term-care reform proposed by both Liberal and NDP governments have demonstrated a profound attachment to brokerage. Both of these earlier proposals for reform essentially extended and consolidated the brokerage model that was already largely in place."

"The rationale for limiting the MSA's right to purchase outside services to 20% of the total budget recognizes how entrenched the brokerage model is in our current system. This rule aims directly at making sure that the MSAs really do become service delivery agencies. This is a terribly important aspect of the implementation."

"In many communities, staff from existing home care programs and the people doing placement coordination services will be the starting point for the MSA. These personnel will help match clients with service providers—they are the brokers in the current system. And even though some of these staff support the government's reform, the temptation to keep on doing what they've always done—especially over long transition periods—will be strong. It's only human to resist change and to focus on those parts of the job that are most familiar."

"That's why putting strict limits on the MSA brokerage activity is absolutely essential. If you amend the bill by removing this provision, you will never get to the amount of integration to truly deliver coordinated care. Brokerage will continue to dominate this system and the reform will be 'business as usual.'"

I could go on, and I hope the members have a copy of this letter and will read somebody who I think does command some respect for her forethought and being in the foreground of reform by people within the community around health reform taking place. I think she's put it quite well.

Sometimes we forget, as members, because we did hear over and over again from some selected groups. Many times we heard from different agencies throughout the province, where their concerns were. But for example, we did hear in Ottawa from Health Care Unions of Ottawa-Carleton, where they felt this was essential—in fact, I think probably would have seen it reduced. We heard from the community health centre network of Ottawa-Carleton, which again supported this area of the legislation. Of course, we heard it from the Ontario Federation of Labour and CUPE, and I think they want it reduced even further.

When we were in London, we had a presentation by the Registered Practical Nurses Association of Ontario, and I'd like to read one paragraph from their brief:

"One of the more contentious issues of Bill 173 is the 20% rule, which will put a limit on the amount of outside service an MSA can purchase for its clientele, as opposed to providing the service itself. This clause will make sure that the MSAs fundamentally remain a service delivery agency, rather than brokers for other agency providers. This provision is a critical one and one that the Registered Practical Nurses Association fully supports."

So we can sometimes point to the fact that we heard from the same agencies over and over again. Let's recognize that we did hear from many other organizations that felt it should be included and felt that as we go about reform—and I'm much too young to recall all the reforms that happened in health care, but when medicare started happening in this country, I'm certainly reminded of doctors' strikes. These were health care providers, primary care delivery agents of health, and yet they went on strike because they were worried about change.

Sometimes change is an awkward thing. It's a difficult thing. We can't think for a moment that a process that is going to change what has been entrenched and what is a brokerage model and to continue the status quo is a real reform. It's not. Reforms are sometimes difficult and it is sometimes demanded upon governments to take leadership. Leadership is going out there and saying, "This is what we see is happening." For us to get away from the brokerage model, the only way we can do it, as some of the presenters that I quoted from today see as essential, is that we move away from purchasing of services, the brokerage model. By placing the limits there, I think we're going to achieve the true meaningful reforms that have been requested of us.

Yes, we didn't hear from the consumers' alliance in every stop, and maybe that's a mistake. Strategically, they would support this change so much, maybe they should've made a presentation every time we stopped in a different community, but because other agencies managed to come before the committee and say that they opposed this—reality is that a good number of those agencies want to be part of the change, and want to be part of the reform that's going to take place. I would hate to limit their creativity in being involved in that change, and hope to see them as partners continue. I'll limit my comments to that and just refer my colleagues to some of the other presentations and not limit ourselves to just the ones that happen to agree with the argument you're making.

**Mrs Sullivan:** On a point of order, Mr Chair: It's my understanding that it's the government's intention to bring in a time allocation motion with respect to this

legislation, probably tomorrow in the House, and what that will mean is that of a 65-section bill, we will have dealt with something less than 13 sections. Issues that have not been discussed are the severance and succession rights, the service from outside the MSAs, volunteers, the assessment process, the confidentiality of personnel records, the appeal process, caregiver disruption and many other very key issues. The significant issue of course is the 80-20 issue on which we have not concluded the discussion.

**Mrs Haslam:** We've had two members spend 20 minutes talking like they were in the House giving a speech this afternoon.

**Mrs Sullivan:** That section is so significant that it merits the kind of discussion and the issues being put on the table, and had you attended in the public hearing process—

**Mrs Haslam:** No, I was there, Barbara.

**Mrs Sullivan:** —for a lengthy period of time, you would've understood the significance of that particular—

**Mrs Haslam:** I would correct you there. I was in that committee.

**Mrs Sullivan:** —section of the bill. Presumably, under a time allocation motion, the government will require that all amendments be placed and considered as moved. I am asking that the Chair take notice that there are specific amendments on which I will be seeking a ruling as to their admissibility, and that includes the package of amendments with respect to the Consent to Treatment Act which in my view are out of order.

**Mr O'Connor:** I appreciate the concerns my colleague is raising. In fact, as the government whip on this committee, my recommendation going back to the House leader will be that we continue our hearings, because I feel we are making some progress. There are certainly times when we do get somewhat long-winded because of the differences of opinions on the bill that's before us.

I will recommend that there not be a motion placed before us so that we can continue this—

**Mrs Sullivan:** Take your motion to your House leader.

**Mr O'Connor:** —that this committee will in fact sit again when the House resumes in another week, that we can then sit on the Monday and Tuesday and proceed with the clause-by-clause. I don't know where the speech came from, but the fact of the matter is it'll be a recommendation from myself to my House leader that we continue to proceed with our deliberations.

**The Acting Chair:** All right then. Unless we receive further notice, this committee stands adjourned until Monday, November 14.

*The committee adjourned at 1804.*

## CONTENTS

Tuesday 1 November 1994

**Long-Term Care Act, 1994, Bill 173, *Mrs Grier* / *Loi de 1994 sur les soins de longue durée,*  
projet de loi 173, *M<sup>me</sup> Grier* . . . . . S-2507**

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York-Mackenzie L)

**Vice-Chair /Vice-Président:** Eddy, Ron (Brant-Haldimand L)

**\*Acting Chair / Président suppléant:** McGuinty, Dalton (Ottawa South/-Sud L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Gigantes, Evelyn, (Ottawa Centre ND)

Jamison, Norm (Norfolk ND)

\*Martin, Tony (Sault Ste Marie ND)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Haslam, Karen (Perth ND) for Mr Rizzo

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

Malkowski, Gary (York East/-Est ND) for Ms Gigantes

Sullivan, Barbara (Halton Centre L) for Mr Eddy

Wessenger, Paul (Simcoe Centre ND) for Mr Jamison

#### **Also taking part / Autres participants et participantes:**

Wessenger, Paul, parliamentary assistant to Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gottheil, Joanne, legislative counsel



S-77

S-77

ISSN 1180-3274

**Legislative Assembly  
of Ontario**

Third Session, 35th Parliament

**Assemblée législative  
de l'Ontario**

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

**Monday 14 November 1994**

**Journal  
des débats  
(Hansard)**

**Lundi 14 novembre 1994**

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

**Long-Term Care Act, 1994**

**Loi de 1994 sur les soins  
de longue durée**



Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

**1944–1994**

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 14 November 1994

Lundi 14 novembre 1994

*The committee met at 1533 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Acting Chair (Mrs Elinor Caplan):** We're about to begin today's committee hearings on Bill 173. We're at the present time in the midst of debate on section 13 of the bill. Just for those who are here today, I'm Elinor Caplan and I'm the substitute Chair of the committee. The procedure that the committee has agreed to and has been working under is one whereby I will recognize any member of any of the caucuses who wishes to speak to the legislation, and ask that members, if they wish a supplementary or anything further, will just signify so that I can ensure that they are on the list.

**Mr Tony Martin (Sault Ste Marie):** This bill that we have in front of us today and have been dealing with for the last number of months, a piece of work or parts thereof that actually has been in front of the Ontario Legislature for approximately the last 10 years, is a very important move forward and an attempt by government to respond to an ever-increasing demand for services in the area of long-term care for our seniors. It comes out of a very sincere commitment and belief and thought that, as government, we need to be responding to the reality that each one of us sees, as we go back to our ridings, to serve those who are most in need. It is a bill that is based on our wanting to make sure that those who are most in need actually get the service they need and deserve.

This bill is not about ideology and it's not about not-for-profit versus for-profit. It's about delivering services to seniors in an efficient, cost-effective, coordinated or integrated fashion. Yes, it's difficult. There are parts of it that are going to be problematic for a lot of groups out in our communities that have, over the last few years, worked very hard at developing a number of services that have come to be relied on by particularly seniors in our communities. What we're proposing here will make the delivery of those services different, will change the names of some of the organizations in some cases or will put the services under an administrative structure that will not perhaps, in organization, look the same or feel the same or sound the same. However, in my mind it is important that we do this.

We're going to be putting significantly more money into the system and we want most of it to go to the actual delivery of services.

We have some choices in front of us, and actually, as we get to the end of this exercise, the choices become relatively simple and clear. We can choose to grow the existing delivery agent system to do the job or we can take this opportunity at this point in history to start fresh with one agent and one administrative structure.

We've been criticized for various pieces of this legislation where it speaks of this particular reality. One that we will come to in the not-too-distant future here is the question of the 80-20 distribution of purchase of service. We're sticking to this and feeling very strongly about it because we do not believe that a truly coordinated, integrated system will happen otherwise.

I said last week, as I spoke to this piece of legislation, that as a government we are beginning, however grudgingly in some sectors, to get recognition for having been able to make some tough decisions in our mandate which recognize the realities with which we have to live. In my experience, this is one of those really tough decisions.

This is a decision to move on an initiative, a piece of legislation that's been before us here, and people before us, in a way that recognizes that we will never again in Ontario have the kind of money to spend that we had in the 1980s in the growing of new agencies. It is a recognition that we can no longer provide a Cadillac version of services to people in one area of the province while on the other hand providing, if I might, with respect to those who perhaps own a Volkswagen, a Volkswagen model of service to people in other sections of the province. That's no longer acceptable, it's not fair and it's not just.

Scarce resources and yet a real need in some areas to redirect the money that we have is what's come into play in the decisions we're making around the growing needs that we see in the area and our responsibility as government to try and, in a responsible and accountable manner, meet those.

**1540**

In my own community of Sault Ste Marie we had two hospitals and a lot of talk over the last 10, 15 years in that community around the bringing together of those services so that we might have a more cost-efficient, effective and coordinated delivery system of services to the people of my city. There was a buildup of opinion over a number of years that we should in fact move to a point where the two hospitals were operating as one.

We've achieved that in the last two years. It wasn't easy. In fact, it was very difficult. However, the reason it happened was the leadership of the two hospitals and the leadership at the community level around the question of

how we deliver health care to our community, and a commitment by our own local government to a study, to hiring some consultants to come in and work with us to put a new plan on the table that would see us delivering services so that both hospitals were working as one.

We now have achieved that, and because of that we are able to deliver hospital care to the people of Sault Ste Marie for approximately \$2 million less a year.

So there are cost savings; there are cost efficiencies in bringing organizations together, particularly if it's done right. I suggest to you that one of the keys to the successful integration of the two hospitals in our community was the commitment that was there by the leadership of those hospitals to actually get it done, and a commitment to the bottom line, which was the delivery of services to people as opposed to a commitment to continuing to prop up organizations that for all the right reasons over the years had developed, but now no longer were appropriate to the need of the day.

I raise for our consideration again here, as I've done a couple of times before, the piece of activity that happened around the development of regional governments in our province. It was thought, correctly at that time, that we would be able to deliver services to larger areas in a more cost-effective, coordinated, integrated fashion if we had regional governments, and they were set up.

The plan at that time was that when the regional governments began to kick in and pick up the pieces and became operational, the smaller government entities would disappear. But that didn't happen, and the government of that day didn't have the intestinal fortitude, I would suggest, to make that happen, so that today we would have a number of regional governments delivering services across our province. Instead, what we have are regional governments and smaller governments competing for the delivery of services and for the tax dollar, and lots and lots of cost inefficiencies.

What I hear some of the folks, particularly across the way, suggesting is that we repeat that history, that we repeat that obvious, in my mind, error of the past.

So here we are today. We have a chance to do something significant. We have a chance to start something new. We have a chance to be courageous in front of a challenge that confronts us all now that has confronted us all for, as I said, about 10 years now. We have a chance at this point in time to do it right and, I suggest, with the piece of legislation we have in front of us and some of the amendments that we are bringing forward, to reflect that we listened to the folks who have come before this committee over the last few months.

Without gutting this bill, without taking away the essence of this bill, we think we have put in front of you something that will serve us well and that all of us in this House will be proud to say we were part of as it becomes more and more important for us personally and indeed for our children down the way.

**Mr Cameron Jackson (Burlington South):** I guess it's safe to say that this is a critical section of this bill for seniors in Ontario. We've always felt it was such and it was identified very, very early in the process of public hearings. In fact, prior to that, we will recall there were

some substantive changes when the bill finally was tabled for first reading and we had moved from restrictions on commercial activities and then we'd moved from that in this same area of the bill and now had removed any reference to the corporate infrastructure or auspice, and we'd now sort of blanketed the entire sector with this 80-20 percentile rule as to what services could be purchased and which services had to be directly supplied by the preferred agency, which is the MSA. Whether we want to call it anything other than the civil service or the bureaucracy, it will amount to that.

We have all sorts of agencies that act as government agencies that have non-elected volunteer boards. The agency receives moneys from the provincial government. So if it walks like a bureaucratic agency and it talks like a bureaucratic agency, then it pretty well is a bureaucratic agency, and that's what the MSA will be.

So the 80-20 rule and why the Conservatives served notice early in the process that we would want to remove the reference to this is that we believe partially in some of the rhetoric of the current government. When the government says, "We want a more efficient system," we think it genuinely believes that. When they say that they would like a more cost-effective system, we think they're right about that too.

When we come to the 80-20 rule we're quite confused why the government can't understand that existing agencies can come together and provide services in a cost-effective way and provide choice. Choice, quite frankly, comes with a lot of protection for the consumer, because in choice you have the empowering ability to appeal your case directly to the supplier of the service to have elements of that service plan changed. In many cases you can actually even have it provided by another agency.

#### 1550

The 80-20 rule attacks the concept of choice, which is an empowering activity for someone who wishes to receive services. The front-line workers who are currently working in the agencies of record, such as VON and Red Cross and a whole host of organizations that have been before this committee, these persons providing service, have a certain independence. They serve predominantly the master, who is their patient. They are not beholden to a government agency to the extent that the government agency funds them and transfer the moneys to them, but generally, the relationship that they have with their employer is one in which they're measured by their compassion and their abilities to perform the service and themselves to become natural advocates for the patient, or for the receiver of the service or the client. We can use any of those words, I guess.

We on this side of the room are very much concerned that by fixating the 80-20 rule you are not just transferring a whole series of employees who will go into an employment lottery at the end of all this, and those who were unionized will probably get a job and those who were not unionized won't get a job. Those who were in supervisory positions with extensive training and field experience will be set aside for employment purposes and people with very little experience and with very little

seniority but who just happen to have landed in an agency three years ago that was unionized are now all of a sudden not only going to see the shakeup of their organization but they're going to get first crack at those new positions.

We should reflect upon the words of the Red Cross, which presented to this committee back in August. It's worthy, I think, to indicate just for the record about section 13 and what probably one of the largest suppliers of services had to say. I just want to briefly quote from their presentation:

"This section stipulates that an MSA may not spend more than 20% of its budget to pursue community services. This requirement is not to be administered globally but applies to each budget line for each of the categories of services" as outlined in part II, section 2: 20% of the budget for community support service, 20% of the budget for homemaking services etc. "This is unlike the present system whereby home care programs broker most of the services they provide, purchasing them from autonomous service provider agencies."

"The Red Cross recognizes that the government is committed to moving away from the brokerage system. In our opinion, the problem with the current delivery system is not brokerage, but a lack of coordination and poor access. We feel that in many situations brokerage can be an efficient system for service delivery.

"Presently, many services are provided effectively and efficiently by a number of established agencies. These agencies have long histories of service to their communities. They are often supported and governed by volunteers who are part of the community. Stable relationships have been developed between provider agencies, care givers and the individuals they serve. Rather than replacing the existing system, efforts should be made to improve coordination and enhance the efficiencies." It goes on to suggest a couple of examples of that.

What the Red Cross is trying to appeal to this committee is to say, allow the volunteer boards—of which you cannot argue that this group of service providers have a monopoly over the membership of the volunteer boards; they are a minority on this board. They can't control the thinking of the board. They can't direct the board.

But either this Minister of Health or this government doesn't trust the very volunteers to whom they have entrusted the responsibility for the delivery of services. They mustn't really trust them very much because what they're saying is: "Look, you have to be guided by a formula. We don't care. We don't want you to get the most efficient and the best use of tax dollars. We don't want you to make sure that access has a very high rating, that those are major considerations so that you can lose a little money in this corner of your programs so that you can provide accessibility to costlier programs that may be required in remote areas within an MSA."

This government's not interested in that. They're basically saying that this one 80-20 formula contains within it all the necessary solutions to improving access and service in long-term care, and that's fundamentally wrong.

It's fundamentally wrong because of exactly what Mr Martin just said. Mr Martin was basically saying, "What's not occurring in one part of the province isn't necessarily what is occurring in another part of the province" would work in his backyard in northern Ontario. We agree with that, and rather than simply saying, "We're going to impose one set of complete, rigid rules," no matter how well the government justifies them, "our rigid set of rules is going to work in Espanola just as well as it's going to work in Kingston, Ontario"—we're in the 1990s here, people. The whole concept of governance and service delivery is being shifted and the shift is true local decision-making. That is simply all we've tried to achieve here, to allow for that flexibility. You're entitled to impose your ideology where you say, "We don't want anybody who has a private home care business operating." But you're not doing this here. You actually remove that.

I think what disturbs me is that you're sort of saying—if in fact private home care is the evil which your government feels it's necessary to have eliminated or stamped out of health delivery in Ontario, then why are you extending that mark against them, why are you extending that to include all these other agencies? Saint Elizabeth has the most Christian charter you'd ever want to look at. Is it because it's a Christian charter that there's something inherently wrong with it?

We can't understand why the 80-20 rule is targeted now towards all of these agencies. It would have made more sense for you to be consistent, to just say, "We want to stamp out the private sector," but leave the VON, which is the direction you were going in, and that was the 10% rule.

It's interesting. I quoted Sid Ryan in the House today, and that was one of the first things he said: "We want this 80-20 reduced to 90-10," and he wasn't happy that the 10% was just targeting the private sector. He wanted to attack all the agencies and he went on to indicate his preference for unionized workers and his lack of support for—in fact his outward disdain for—the growing numbers of volunteers, which is again another contradiction for the government.

The point is that Sid Ryan indicated that it was a sad day for this province because we were using volunteers more in the health delivery system. Well, I've got news for you. This is the direction we're going to have to go in as a society if we want to survive today. Twelve per cent of all of our citizens are above the age of 65. When the baby-boomers are 65 years of age, we'll be 33% of the population.

**Interjection:** Oh, come on.

**Mr Jackson:** Thirty-three per cent of the population. Now, if we think we're going to deliver all these home care services and community-based services, because we know we've cut off institutional care to upper limits, then we're dreaming in Technicolor if we're not going to expand, to celebrate and promote the volunteer sector.

Again, earlier in the House today I made reference that a lot of the government members have accused the opposition members for their concerns that they had heard about the Quebec system and why volunteers were

being driven away, and Mr Quirt at the time said that he had seen some evidence but not really very much evidence. He begrudgingly indicated that there was some evidence but the degree to which it was very powerful evidence he wasn't sure.

I read into the record today a quote from the Quebec government task force report on health promotion, Objective: A Health Concept in Quebec. I want to quote right from the report. It stated that the government has often been reproached for killing the volunteer movement by systematically paying people in the community to do the work they formerly did without pay. The report stated that charities previously providing services in Quebec have progressively disappeared and the overall wage costs for services increased.

1600

What we're talking about here is the comparison. We are behind Quebec in terms of this reform. In Quebec they have what are called local community service centres—CLSCs they are called in Quebec. In Ontario we have MSAs. A very pro-labour Liberal government in Quebec over a period of almost a decade, and prior to them the separatist Péquiste government in Quebec, developed the model along the lines, but driving the engine of reform was how they were going to manipulate the labour pool of services and how they were going to redefine the delivery system through the agencies. And when all the cutting and slashing was finished, most of the blood on the floor was from groups like the Red Cross and VON and Saint Elizabeth's and various other agencies that were providing large support services.

To quantify the dollar loss was easier to do in Quebec, I'm told, than the numbers of volunteers, because you had multiple volunteers. You'd have somebody who would do Meals on Wheels and then take someone to a doctor's appointment and then volunteer at an Alzheimer centre for respite. So that was always very difficult to monitor. But what was easy to quantify was the huge numbers of dollars that these agencies were putting into the cost of delivering health care in the province of Quebec. That's where they expressed serious reservations about revenue loss. So who makes it up? The government. The taxpayer makes it up. Nobody else; the taxpayer. And because we have only one taxpayer, they're the ones who are going to fit additional costs that quite frankly are unnecessary because the government has walked away from the commitment to do this in the most efficient, effective, cost-efficient, accessible way possible.

Because they're not, they have a formula, so they can simply turn to the minister of the day and say: "Look, you've only given us X number of dollars. We can only spend 20% with this agency that can deliver the service for \$6.50 an hour, but because we have to buy 80% of our service from within our agency, our agency costs are \$8.50 an hour."

You can look at that two ways. You can say the \$2 difference is just the cost of government. You can look at the \$2 difference and say, "Well, if we could have more than just a 20% purchase of the Red Cross, then we could get our costs down. We could save money."

What a terribly foreign concept for politicians in the

1990s: We could save money. Or better yet, the one that I like the most of all is, how many more seniors could we service for that \$2 an hour? How many people could we take off a waiting list? What new activation programs could we get into over in this part? Because in our given community in northern Ontario we have a unique problem and we really can't be suffered with an 80-20 rule and we can't be suffered with a global budget that says we can't look at developing some new programs because we have a disproportionate number of native Canadians with their unique needs in our region and we just can't find the money.

When we say that we feel this is one of the most important sections, we do because we see beyond just the bill. We see its implications for the actual application of this legislation, what it will be like four years down the road when everybody's plans have to be etched in stone and there's no turning back.

I wish I could go on further about concerns I have about the volunteer sector, a new figure which is now emerging based on some statistical information about the costs of the volunteer sector, who, quite frankly, if they can go down the street and volunteer for the Red Cross like they always have, and the MSA purchases services from the Red Cross, then that volunteer has no reason to leave.

There's no question any longer that that volunteer is not going to show up. They will still show up and do their driving Monday, Wednesday and Friday, like they have done for the last five years. But if under the 80-20 rule, Red Cross doesn't get to have any of its services purchased, they have to say: "Call the MSA. They're in this government building. Go ahead and make application, because they may or may not want you to volunteer."

We're concerned that this has been quantified to equal an amount of about \$9 million at the VON, the amount of the services these volunteers are providing; \$18 million at the Red Cross; and the Human Services Alliance is approximately \$10 million. That's \$37 million. Again, if we think of our \$2 argument, \$2-an-hour difference, we have to ask ourselves, can taxpayers really afford \$37 million more not to help one single additional citizen, or for \$37 million, how many more seniors could we provide services to and take people off extensive waiting lists in this province? That's what's at stake with this 80-20 rule in clause 13 and why we feel so very strongly.

On just one little final note, it should be put back into perspective. We are talking about a sector of women workers. No matter how you call this, we are talking about women workers. I know the government's been criticized about their Jobs Ontario plan, and they say how successful it is. Well, it may have been successful in getting people to do certain things, but 90-some per cent of the people they've helped have been men. I'm still waiting to hear what this government is going to do positive for women, but certainly this legislation is going to displace a lot of them, and if they're not unionized there's no guarantee they're going to get their jobs back, whether they resurface in a government position.

Today in the Toronto Sun is a wonderful article about

a book entitled Canada's Best Employers for Women. It goes on to talk about all sorts of contemporary circumstances that are helpful for women with respect to employment.

The book acknowledges that the health care sector, especially in long-term, is a target area where it's disproportionately high in women workers. It also compliments the VON as one of the very best employers in this province. I think it's rather tragic, given the circumstances we find ourselves in with the economy, that women workers should be discriminated in such a fashion by this government.

These are all the things that are wrong with an 80-20 rule that's probably, according to this government, going to work well in Kingston, just as well as it's going to work in Espanola, and we can't agree with that.

**Mr Jim Wilson (Simcoe West):** On a point of order, Madam Chair: I think it's very important to the debate on this clause that we see the government's rumoured amendments that are to be tabled, or were supposed to be tabled I think by now, with respect to the labour provisions. So I just ask the parliamentary assistant when those new amendments are coming forward, because I think they're important to the 80-20 rule discussion we're having.

**The Acting Chair:** Well, it's not a point of order but it is a legitimate question to the parliamentary assistant.

**Mr Paul Wessinger (Simcoe Centre):** I understand that copies are being made now and they'll be shortly filed.

**Mr Jackson:** On a further point of order, Madam Chair: Is it fair to ask if any amendments deal with displacement of workers, which is the point we've been raising? If so, it may be appropriate to have a motion to stand down this section.

**The Acting Chair:** I'm not going to rule on whether it's fair or not to ask the question, but I will ask the parliamentary assistant to give you his best answer.

**Mr Wessinger:** There are amendments I believe already filed, and I don't believe the additional amendments in any way substantially change the thrust, the general principles of what is already filed in the existing amendments. So the general thrust of the amendments will be basic to preserve existing rights.

1610

**The Acting Chair:** The second part of your question to me was a request to stand down section 13. Is that a formal request?

**Mr Jackson:** Yes. My options are to call a recess until we get the amendments, which I'm loath to do, given the other complication with this evening, which is our right to get out and vote municipally, but I'm at a loss to determine why we can't have these amendments.

*Interjection.*

**Mr Jim Wilson:** It's important. How are we supposed to debate this section, which virtually changes the—

**The Acting Chair:** I'm going to ask for order. A legitimate question has been asked.

*Interjections.*

**Mr Jim Wilson:** I want to know what's going to happen to these—

**The Acting Chair:** The answer has been given. You may not like the answer. You now have options available under the rules of procedure of this committee as to how you'd like to proceed. Mr Jackson, you have the floor. Have you finished your comments?

**Mr Jackson:** I'll pass; I have completed my comments on this section.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I arrived this afternoon to hear Mr Martin talking about Bill 173 from his perspective. I heard him say things like, "We will be proceeding with this and we are really going to push this section." Then the thought ends. That is what happens on this issue every time we bring it up. There is no real reason for the 80-20. He brings up as his last point that, "We've listened to the people," and he also brings forward that this is a cost-effective measure. I had no difficulty in coming to the meeting today with a dozen briefs that counteract those three statements.

I want to begin by one from the older adult centres. The statement was made to us that it's not apparent to the Older Adult Centres' Association of Ontario what the justification for this actual ratio is. It's unclear as to why the restriction was made at 20% rather than the more acceptable 40% or 50%. That question has been asked over and over, both by our caucus and by members of many organizations all through the hearings, and indeed before the hearings.

We also know that there is an atmosphere of divisiveness being created in this province by this bill, and I regret that immensely. The division is coming between people like the Red Cross, the Catholic Women's League of Canada, the Council on Aging, the Ontario Psychogeriatric Association, the Saint Elizabeth Visiting Nurses' Association, Victorian Order of Nurses, Villa Charities.

All of these people, in their mission statements and indeed in their actions in some cases for upwards of a century, have been acting on behalf of seniors. Now we see that there are certain seniors who are not agreeing and we have divisiveness even among the seniors' groups. Today, we have indeed some seniors coming to the province saying that we are delaying the bill and that they would like to see us do differently.

I think that there is confusion created in those communities. I regret the divisiveness because the groups I mentioned have been acting on behalf of seniors and have been indeed caring in a compassionate, efficient manner for seniors through all their existence.

I wanted to bring to you from Ottawa the Council on Aging's remarks on this particular clause:

"Bill 173 provides a restriction that not more than 20% of the amount budgeted for the four MSA service areas be used for the purchase of services from other service providers outside the MSA. This will result in less flexibility in the design of the MSA in...Ottawa-Carleton. With the recent inclusion of recreational and social services within the MSA as well as the high level of commercial involvement in the provision of homemaking services in our region, this 20% target may be very

difficult to achieve"—I would say, a very kind statement.

"The council is concerned that adherence to this provision may result in considerable disruption in service to the senior consumer." That is a very highly representative group in the area that I represent.

The costs that are given are certainly questionable, whether it be in the consultants' report or the costs that it seems impossible for the government to provide. We haven't had one cost-benefit analysis on this bill. We've asked for it; we've never had it.

This is from the regional municipality of Sudbury. I'm going to suggest that from all over the province we are getting deep concerns about section 13.

"As long as an efficient service is being provided, the provider is irrelevant. Local communities should be allowed to determine their own system. Contracting out some services may prove to be more economical, as well as more efficient. Thus, we suggest that the arbitrary capping be eliminated and that...subsection 13(2) be repealed." How much clearer could that be?

This is even a more poignant one from the Lambton Alliance, the Lambton Seniors Association: "It is a known fact that for-profit agencies can often provide a given service at the same quality level as a not-for-profit agency at substantially less total cost and still show a profit. For instance, we know of one service provided locally by a for-profit agency in direct competition with a well-known not-for-profit group which has a total cost"—the for-profit at \$9.70 per hour and in the latter case of not-for-profit, \$37.50 per hour.

That's just one example from one part of the province. What we see here is not only an attack, however, on the for-profit, but we see an attack on the not-for-profit. There is only going to be one choice in a community. I was very interested today in the House to hear the minister, and I certainly want to pursue this, suggesting that if a person doesn't like one MSA, they may go to another MSA.

I stop my remarks at this point to ask the parliamentary assistant if he can enlighten us with what the minister was saying in the House. I've not heard that. Would he, from his insights and his work in the Ministry of Health, be able to tell us what she was talking about today?

**Mr Wessenger:** I'm not aware of the minister's remarks so it would be difficult to comment on them without seeing them in context.

**Mrs O'Neill:** It was in answer to a question in the House today placed on this very matter. I would place that question, because if there are alternatives among MSAs, for one thing, I understood that in most communities there will be a very limited number of MSAs and certainly in smaller communities but one. I would appreciate knowing what she had in mind.

I go back in my remarks to the costs involved.

The senior citizens centre in Windsor brought the following concerns to us: "Any limitation on the purchase of service should be applied globally and not categorized. Not to do so will fragment the delivery of service and will require undue"—this is a point that I don't think has

been brought forward—"monstrous recordkeeping and mammoth administrative bureaucracies. People's needs and the appropriate responses to those needs do not fit into neat categories day by day or month by month. The whole person must be treated. Coordinated, not categorized, services are required. The intensity of services and their priority can and do vary and fluctuate frequently."

That is the problem with this section of the bill. We're tied into this forever, 80-20. There's no opportunity, once the four-year transition period is over, to ever change this. Even if a board of volunteers in a community who are there on a day-to-day basis make another decision, they are tied to this.

As the retired persons who presented in the media studio this morning said: "We don't know if this going to work, but we've got to destroy everything. Then if it doesn't work, what have we got to go back to?" That's the way the people in the communities are beginning to see this bill.

1620

The Community Support Coalition of Ottawa-Carleton expresses its concerns, and I think it does it very well:

"The Community Support Coalition of Ottawa-Carleton recommends the removal of the 20% limit on purchase of service by the multiservice agencies in section 13(2). Community support services in Ottawa-Carleton are well developed. Coalition members pioneered some of our community support services in Ottawa-Carleton nearly 40 years ago, and our network has expanded so that all of the region is now served.

"Agencies were created in response to expressed community need. A great deal of effort has been expended in planning and coordination by the Council on Aging of Ottawa-Carleton," which I quoted earlier, "and between the agencies themselves, to ensure lack of duplication as they emerged. Clear geographic and service boundaries have been established; services are provided in French and English where appropriate and some partnerships between service providers and multicultural groups have already been developed," and certainly are continuing to be developed in the long-term-care planning process of the DHC.

"There exists currently in Ottawa-Carleton a well-coordinated network of services that puts consumer services first. We are the foundation of the future long-term care system in Ottawa-Carleton and we urge the government to build on that foundation.

"However, it is clear to us that the implementation of section 13(2) would require existing agencies to be absorbed into a larger body and cause severe disruption in service provision. Simplified access, coordination and service delivery can be achieved without this measure. It is unnecessary in an area as well-developed as Ottawa-Carleton."

People resent being told how they have to do things when they know their own communities. Right here in York, the Community Agencies in Partnership I think volunteered to be a pilot MSA, but of course we're not going to have any pilots. We're just doing it this way because we feel we've got to push ahead. Mr Martin said

that. They're not taking no for an answer. They're going to do it this way.

"Community Agencies in Partnership believes that a limit of 20% on purchased services should not be prescribed in legislation. It is our position that this limit should be eliminated so that each existing community can determine the mix of service providers and agencies that best meets its individual characteristics and future service needs."

Isn't that rather simple? Isn't it very useful to know that some people know their communities and know the most efficient way and the most effective way to provide services there? Hopefully these are going to be the people who will be involved in governance and are indeed involved in governance at the present time.

Now, as I said before, there seems to be this great desire to build a gulf between the providers and the consumers, a gulf that I don't think has ever been there in Ontario. I really do believe, and as I've said before, I speak from personal experience, that the providers in this province can hold their heads high, and the consumers are the ones who reinforce that on almost a daily basis; very few complaints about home care in this province other than the access, which we have heard and which we know how to remedy.

The Ontario Home Health Care Providers have said to us, "The impact on businesses founded and developed by Ontario entrepreneurs will be disastrous"; Ontario entrepreneurs, people who provide jobs. "As a result of this bill, they stand to lose their businesses."

"Bill 173 doesn't reform the...system," they say, "it destroys it," and certainly what I have been seeing from many of these other organizations says the same thing. The private companies in this province employ 20,000 nurses, home support workers, occupational and speech therapists, physiotherapists and administrative staff.

This group, the health care providers, have told us, "Models like the government's proposed MSAs have been tried and abandoned in other countries, most notably Great Britain and Sweden." Indeed, Manitoba, which cut out the private sector, now wants to introduce some of that. Why can't we learn from those experiences? Those experiences have been brought to us throughout these hearings.

The bottom line here is that there will be people put out of work by this piece of legislation. I still fail to see that we are going to have a job-creation experience here. If we do, it will be at the expense of volunteers.

The Saint Elizabeth visiting nurses have provided exemplary care and have reached out to other groups and have an integrated service within this particular community and indeed beyond. "The 20% ceiling eliminates consumer choice," and indeed it does. Those who have chosen Saint Elizabeth Visiting Nurses' Association over the years have done so for very special reasons, as have they chosen other organizations and other providers for very special reasons. Why does the 20% have to sit and thus eliminate choice? I don't think that the elimination of choice is a very politically correct move in 1994.

The St Joseph's General Hospital in Thunder Bay,

where I think we began our hearings outside of this city, brought to us a very comprehensive brief. One of the highlights of that brief was:

"The rule on the purchase of only 20% of services from outside the MSA will eliminate the use of many excellent support programs," and every community is now beginning to understand that. The groups that they have depended on over the years, whether it be the Red Cross or whether it be the VON, are now in jeopardy. Will they or will they not fit this 20% formula? Certainly they won't all fit.

I think the Haldimand-Norfolk Transitional Steering Committee presented us with a very worthwhile recommendation on this particular section of the bill:

"That the government eliminate the 20% figure and give each MSA community the flexibility to determine its level of outsourcing of services. Guidelines to determine the level of outsourcing should include the cost of the service, the quality of the service and the waiting lists for services delivered by an MSA."

Now, wouldn't that be a novel thought in reference to Bill 173? That we would actually provide services through the MSA with criteria such as cost, with criteria such as quality, with criteria such as waiting lists? We still don't have the answers on waiting lists. We don't know how long people will have to wait. We know the only guarantee of Bill 173 is that they will be put on a waiting list. How long is reasonable?

We know now where there is competition, where there is cooperation, where there are the beginnings and indeed in many cases solid integration of services, the waiting lists are really rather short in this province and I think we should be proud of that. We have not had complaints from people about waiting lists. As I emphasize, we've had complaints about access. You don't have to destroy a system to gain access to it, and that unfortunately is what Bill 173 is doing.

I find this entire group of briefs, only a dozen of which I brought with me—I'm sure I could have found four dozen of these easily because these came to hand in 15 minutes of brief scanning.

To say that what is being done in Bill 173 is what was heard either in this city or in the various communities that we went to is just not true. I have read verbatim from the briefs that were presented to this committee, and I'm sure that if we were to go out into the communities now, now that people are beginning to know what this bill is about, we would get even more explicit briefs, even more explicit recommendations and people would be coming in larger numbers to tell us how they feel.

So I end with the statement of the coalition of consumer and provider groups that now numbers almost 25, and they are, as I've said to you, the Villa Charities, the Victorian Order of Nurses, the Canadian Red Cross, the Catholic Women's League of Canada, the Council on Aging, the Ontario Association of Residents' Councils. These are all grass-roots organizations and they have told us they are grass roots when they came to us. They are from all across the province. These are not Metro centred; they are indeed province-wide.

The coalition is urging the members of the standing committee on social development to amend section 13 of the bill which would permit local boards—people who live in the communities, people who have ownership, people who have real concerns, people who have real understanding, people who know the strengths of their communities—to determine the structure of the multi-service agencies and to let communities decide the mix of services between the MSA and other care providers.

**1630**

These are logical, reasonable requests. We in the Liberal caucus cannot understand why this particular mandated, autocratic section has to stay in the bill. We have not yet had a reason. Even, as I say, when Mr Martin had his opportunity today to say they were going to push ahead with this particular section, and on many other occasions members of the government have had opportunities to suggest why this is necessary—can't get it. It's attacked on every existing service in this province today, whether it's profit or not-for-profit. "We're going to do it a different way. We don't really know why. We have no cost-benefit analysis but we're going to do it this way because Bill 173 has come out of the chopper this way and we're going ahead no matter what anyone says to us."

This to me is unsatisfactory. I think it's irresponsible and I think I'm being kind at the moment.

We cannot support this. We will not be supporting it. If anything, the groundswell against this particular section and indeed the groundswell against this bill is growing. I hope the government is understanding that growth.

**The Acting Chair:** Just for those people who are here and watching and for some of the members who came in after I had already stated where we were: While we are debating section 13, at this moment we're debating a motion by Mrs Sullivan to replace section 13 with an alternative. That's the motion before us and when everyone has had a chance to speak on Mrs Sullivan's motion there will be an opportunity to vote on that motion. Did you have anything further you wanted to say, Mrs O'Neill?

**Mrs O'Neill:** Just to go back to the motion placed by Mrs Sullivan, what we have seen here is the request to have communities have the model that they feel would best suit their needs. It's very closely tied of course with the 80-20 mandatory capping. We have consideration that the MSAs are going to look after all people in need of long-term care whether that be the disabled or whether they be children's services and we have here the request that, if a service, as I read from Ottawa-Carleton, has been well built up—and indeed in many communities it has; indeed here in Metro Toronto—there is certainly much to build on, that be done.

What we see with this bill is a complete destruction of foundations; a complete destruction of partnerships that have been built and a rearrangement under a new bureaucratic organization that is going to be formed with a steering committee and staff choices made of an MSA, positions of great trust with very few people involved. We are certainly concerned about the—what should I say?—the democratic process connected with the MSA

and the respect of the existing providers, the respect of the services and the respect of the consumer that may be lacking.

We have no guarantees with Bill 173 and that, I think, is a grave concern. All we have is a prescriptive document with very little that can convince us that the consumer and the services will be as they are, or indeed, improved as we've been promised. That's all for now.

**The Acting Chair:** I'd like to just clarify with the committee members whether or not there is agreement that speakers be permitted to speak in the order in which they put their hand up or whether we are rotating through the caucuses. We had some discussion at the beginning of the meeting. It was my understanding that it was going to be in order of when they put their hand up. There is some suggestion now that we should rotate through the caucuses.

**Mrs O'Neill:** We have been doing it formerly, Madam Chairman.

**Mr Larry O'Connor (Durham-York):** We'll continue, and what we've usually done, too, is limit it somewhat so that all the speakers who have put their hand up would have an opportunity to do that. I think Mr Wilson would probably—

**The Acting Chair:** I just wanted to clarify that at the request of the government whip.

**Mr O'Connor:** —have very brief comments.

**The Acting Chair:** Mr Wilson, Ms Carter and Ms Gigantes are on the list, as well as Mr Crozier. Mr Wilson, you have the floor.

**Mr Jim Wilson:** On a point of order, Madam Chair: The House is not sitting any more, so why is the committee sitting?

**The Acting Chair:** There was agreement among the House leaders that the committee could and would be permitted to sit beyond the time that the House adjourned.

**Mr Jim Wilson:** I think, as long as I can get back on the list, I'll yield to Ms Carter, but not before I once again ask the parliamentary assistant: Some 40 or 50 minutes have passed since I asked for the labour amendments that are to be tabled today. I was wondering if they are now available. This building's full of modern photocopyers that would have copied them several hundred times over by now and it is crucial to this part of the bill. I'm thinking of asking for a 20-minute recess, which is our right, if we don't get these amendments.

**Mr Wessenger:** I understand they're expected in about five minutes.

**Mr Jackson:** Then we'll take a 10-minute recess.

**Mr Jim Wilson:** I think in the meantime, Madam Chair, perhaps you could continue with your list.

**Interjection:** Yes, let's continue with the list.

**The Acting Chair:** Ms Carter, you have the floor.

**Ms Jenny Carter (Peterborough):** I certainly agree with previous speakers that this part of the act is absolutely crucial. The question of whether we have an integrated model or a brokerage system is, I would say, the crucial difference between the government position

and the opposition position. We're all agreed that there should be integrated access, that one phone call should be able to reach all the different services required, but it's what happens after that, whether we still have a system of separate agencies or whether we have an integrated system, that we're looking at here.

I'd like to address this first of all under two main headings, which are not entirely separate. The first is cost. A lot has been said on the other side of this room about cost. I think we all agree that the demands on these services are going to increase as time goes on. We all know that the population of senior citizens is increasing, the amount of money available to the government from taxpayers is not increasing, so we have to make sure that we spend our money in the wisest possible way.

The Price Waterhouse report that was done for the Senior Citizens' Consumer Alliance for Long-Term Care Reform, according to some people, has been discredited because we're told that individual agencies do not have high overhead administrative costs. I'd like to suggest that's not entirely the point, because it isn't just the internal costs of each agency that create the final cost of the system; part of that cost is the interaction between different layers, different parts, different administrations, so that a means of decreasing the cost is to integrate the system and to decrease that need for complex communication.

1640

I'd like to read some paragraphs from the submission made by Jane Leitch, chairperson of the Senior Citizens' Consumer Alliance for Long-Term Care Reform. She says: "However, one of the greatest obstacles to multi-service agency creation is that many existing provider agencies remain sceptical that MSAs will be more cost-effective than the current system, since their own administrative costs are quite low. What these agencies fail to recognize is that the cumulative impact of a multitude of agencies, each with its own administrative expense, represents a tremendous cost to the system as a whole.

"In reviewing the expenditure on the current community-based long-term-care system, Price Waterhouse concluded that, conservatively, administration and overhead account for 30%—almost \$200 million—of the expenditures within our current community-based long-term-care system, but within a fully evolved multiservice agency model it is conservatively estimated that expenditures on administration and overhead will fall to 16.2%, allowing almost half of our current system's administrative budget to be redeployed into service delivery."

At this point I'd like to read a paragraph from a letter from Carol Kushner to Larry O'Connor. Under "Brokerage," it says:

"The system in which others purchase care and services on behalf of clients, brokerage, has characterized Ontario's long-term-care system for a long time. Brokerage requires far more communication time and adds a layer of complexity to an already complex system.

This has been ably demonstrated in a study done in Calgary in the mid-1980s by Bonham and Carter. Dr Bonham was then the city's medical officer of health and

he was able to test a brokerage model and a consolidated model in two segments of the city.

He found clear evidence that brokerage took up more time, tended to be associated with longer use of the program and cost a whopping 48% more per client. In explaining the advantages of a consolidated model, where the community nurse was doing both the assessment of need for care and the provision of care, he used to joke, 'It doesn't take nearly as much time to consult with yourself,'" and this is what we're looking at here, much better integration.

To return to Jane Leitch, she says: "When case management is separated from service delivery, as in our current system, there were 36% more visits, each visit cost 21% more and clients remained on the caseload for longer periods of time. Taken together, it was calculated that the total cost of the brokered model was 48% higher per client."

Not only is this inefficient financially, but it does impact on the wellbeing of the clients, because we have had for many years a demand for reform of this system, and I think the key element in this demand for reform has been the fragmented nature of the system.

I have heard from individuals in my own community who have said, for example, somebody lived in housing that was meant for disabled people. She was disabled, she was in a wheelchair, but there was a package of care that she had to receive in order to have any care at all. The result was that she received more care than she needed, obviously at a cost to the taxpayer and with a nuisance value to herself. This person has finally achieved the care she wants, no more and no less, after eight years of having to manoeuvre with the system and battle with it, obviously at cost to the taxpayer and wear and tear to herself.

I know of another example of somebody who wanted a little help with the housework but was forced to accept personal care that she didn't need as part of the package, and so it goes on.

When we look at integration, we're looking at greater financial efficiency, but we're also looking at something which is much more flexible and much more responsive to the needs of the consumer.

I would point out that this is not a criticism of the efficiency of individual service providers—we all know that individual agencies have done a wonderful job. The point is that the cumulative effect of having a multitude of single service providers operating separate and apart from the independent case management infrastructure creates a tremendous administrative burden for taxpayers and inconvenience and lack of properly adjusted service to the clients.

Another question that has been raised in this context is the question of volunteerism. We're being told that volunteers will desert the system and that this is another reason why costs will rise instead of falling. I would like to dispute some of the so-called evidence that has been brought for this.

There have been comparisons with Quebec and I would like to point out that there is no exact parallel with

the experience in Quebec. First of all, although we have been accused of establishing a bureaucracy, the MSAs, as proposed in the act, are extremely democratic and community-based and involve volunteer, locally elected boards, so that this already involves volunteers, not bureaucrats, in the basic structures we are creating here. In Quebec, the boards that were set up as a result of their legislation gave more places to professional groups, even on boards of directors; in other words, they went in the opposite direction to us. The boards of directors were not community people; they were professional groups.

Also, there has been some suggestion that we would kill the volunteer movement by paying people in the community to do work they formerly did without pay. This is absolutely not part of the legislation that we are putting forward. The government of Ontario has no intention whatever of paying multiservice agency board members or volunteers; Bill 173 is quite clear on that. We are not trying to expand the field of paying jobs into the field now occupied by volunteers; that is definitely not the case, I believe, and it is also been expressed by other people, that where you have a community-based integrated system, it is going to be more, not less, accessible to volunteers than the present system we have.

To say that volunteers only do what they do because there is a certain label on a certain agency is to insult volunteers. I think they do what they do because they see a need in their community and they want to go out and serve that need.

I would also like to address the question of choice. It's been suggested that somehow under the system advocated in the bill we are going to lose choice. I'd just like to point out that there never has been any choice. There has been a variety of organizations such as Red Cross, VON and so on. The one that a consumer finally ended up with was something that depended on the mechanisms functioning in their own particular area.

Some areas are served only by the Red Cross. I believe some of those are some of the more inaccessible rural areas. In other areas, there is a board of health. I think this is the case in my own area, which accesses the services of the different agencies but would not do so on the basis of individual choice. I know certainly in one area whether you get Red Cross or VON or whatever depends on the day of the week on which your request for help happens to go out. I believe this is the case with other services. I am not aware that somebody accessing our long-term care services in this province would normally have any choice of who would provide that service.

I would also like to point out that this 80-20 rule, which as I have said is key to this legislation, is not aimed specifically at for-profit organizations; that 20% includes for-profit providers and other providers. To say it is an attempt to get for-profit agencies out of the system is not accurate. I do agree that by integrating the services into the multiservice agency we then put them on a not-for-profit basis, but it is my feeling that when something is being run with taxpayers' money on a shoestring and we are trying to get the very best value, we should not be planning for a margin of profit, we

should be planning for the money to go into those front-line services.

#### 1650

While I'm talking about money, there also seems to be an implication flying around that somehow money has been taken out of the system, that people are going to lose jobs, that there are going to be fewer services. That could not be less true. I know of at least one past client of the Red Cross who has presented to a committee and has actually written a letter to my local newspaper saying that there will be no further services, that we're destroying the system.

I don't know who has spoken to her, I don't know what that person has said, but I do know that we have put vast amounts of extra money into this system, that areas which were not properly serviced previously are now going to be serviced, that in fact most consumers who were already accessing services will notice no difference, that they will probably continue to get the same care provider. We are in fact creating 5,000 extra front-line jobs, so that talk of people losing their jobs is again alarmist, because jobs will not be lost, jobs will be gained; they may come under a different heading.

But another point I would like to emphasize, and I think this has been very underemphasized in general, is that the act provides a transition period of four years and it is only at the end of that period of time that all the requirements of the act have to be met, so to people who fear that suddenly, overnight, the agencies that are delivering services are going to be overturned and the staff are going to be scattered, this is not happening. We're not asking for massive disintegration; we're asking for the existing agencies to cooperate more and more closely over a considerable period of time so that at the end of that time they will in fact have merged. I don't think that is the same thing as abolishing agencies.

Admittedly, if we are to achieve the economies that we expect to achieve by the time that merger is complete, there will not be the same number of boards, there will probably not be the same number of administrators there are in the field at the present; there will, however, be more front-line workers, not less. As has been said, there are labour amendments coming in and we're certainly concerned to make sure that the transition from one employer to another is going to be fair and orderly. I do not see vast sums going out in severance payments; I don't think that is what is going to happen.

I would also like to point out that we are continually being given lists of organizations that are opposing this legislation. They are, I believe, almost entirely provider organizations. The people this legislation is focused on, the people it is trying to assist, are the consumers, and I think that for anybody to either scare consumers by making them feel that they will not be looked after or to scare employees by making them feel that they will lose their jobs is something that is not worthy of anybody who really is concerned with the best outcome for the people of this province.

In conclusion, I would like to read the last paragraph of the Jane Leitch report from the Senior Citizens' Consumer Alliance for Long-Term Care Reform, which,

as I have said before, does represent over a million people. She says:

"We're therefore looking to our politicians and government decision-makers to do what is so clearly in the public interest. We're fully aware that doing the right thing is not always easy. The status quo is often an attractive alternative to change. But we're convinced that without a fundamental restructuring, we could lose access to the kind of long-term-care system that reflects the values of our society.

The success of long-term-care reform and multiservice agency creation is critical to the wellbeing of elderly consumers and our families. We do not want to see this reform delayed any longer and we're not prepared to sit quietly and allow providers and politicians to make short-term political compromises which will ultimately undermine the system as a whole.

We've all been talking about reform for years; now we want to see some action." I will also conclude at that point.

**The Acting Chair:** I believe that we have agreement. There has been a request that we vote on this motion by Ms Sullivan at this time. As there is another amendment to section 13, and since there seems to be agreement that we vote on this section now, the remaining speakers on the list—Mr Wilson, Ms Gigantes and Mr Crozier—I suggest be the first speakers when the committee next sits, if that's agreeable. The agreement is that we vote on this motion at this time and then Mr Jackson will have the floor.

**Mrs O'Neill:** Recorded vote.

**The Acting Chair:** A request for a recorded vote. Do you need to have the amendment read or does everyone know where we are? I just want to make sure. We're on

section 13 of the bill, and this is a Liberal amendment that's been placed by Ms Sullivan.

All those in favour of Ms Sullivan's amendment, please raise your hand.

**Ayes**

Crozier, Jackson, O'Neill (Ottawa-Rideau), Wilson (Simcoe West).

**The Acting Chair:** Those who are opposed to the amendment?

**Nays**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessinger.

**The Acting Chair:** The amendment to section 13 has lost.

**Mr Jackson:** Earlier, when I quoted from the book Canada's Best Employers for Women, I indicated that it was the VON. In fact, to correct the record, if I may, it is the Saint Elizabeth organization, which was established in 1908. I appreciate the opportunity to correct the record. Both deserve to be in the book, frankly.

Given that most of us around this table would like to vote before 8 o'clock in our municipalities, I'd like to move adjournment so we could participate in the municipal election this evening.

**The Acting Chair:** A motion to adjourn is not debatable. I'm going to call the question. All those in favour of adjournment at this time? Any opposed? The motion to adjourn is carried.

For those who are interested in the proceedings of this committee, the committee sits next at 3:30 tomorrow afternoon.

*The committee adjourned at 1656.*





## CONTENTS

Monday 14 November 1994

**Long-Term Care Act, 1994, Bill 173, *Mrs Grier* / **Loi de 1994 sur les soins de longue durée,**  
projet de loi 173, *M<sup>me</sup> Grier* . . . . . S-2525**

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York-Mackenzie L)

**Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

**\*Acting Chair / Présidente suppléant:** Caplan, Elinor (Oriole L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

\*Gigantes, Evelyn, (Ottawa Centre ND)

Jamison, Norm (Norfolk ND)

\*Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Caplan, Elinor (Oriole L) for Mr Beer

Crozier, Bruce (Essex South/-Sud L) for Mr McGuinty

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

Malkowski, Gary (York East/-Est ND) for Mr Rizzo

Wessenger, Paul (Simcoe Centre ND) for Mr Jamison

#### **Also taking part / Autres participants et participantes:**

Wessenger, Paul, parliamentary assistant to Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gottheil, Joanne, legislative counsel



S-78

S-78

ISSN 1180-3274

**Legislative Assembly  
of Ontario**

Third Session, 35th Parliament

**Assemblée législative  
de l'Ontario**

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

**Tuesday 15 November 1994**

**Journal  
des débats  
(Hansard)**

**Mardi 15 novembre 1994**

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

**Long-Term Care Act, 1994**

**Loi de 1994 sur les soins  
de longue durée**

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott



*50th anniversary*

**1944–1994**

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 15 November 1994

Mardi 15 novembre 1994

*The committee met at 1531 in room 151.*

## LONG-TERM CARE ACT, 1994

## LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Vice-Chair (Mr Ron Eddy):** Good afternoon, ladies and gentlemen. Welcome to the social development committee, which is presently considering Bill 173, An Act respecting Long-Term Care. The committee is considering the bill clause by clause and had proceeded to section 13.

**Mrs Barbara Sullivan (Halton Centre):** Mr Chairman, I want to raise a point of privilege before the committee which I raised earlier in the House today. In order to do this, I hope that you will give me an opportunity to make an argument, because my point of privilege is that the members of the committee have been misled through information which was put before them as part of a presentation which was made to the committee.

You will know that much of the debate with respect to long-term-care reform is not with respect to the contents of the reform itself but the shape of the methods of delivery of a reformed long-term-care system. There is little disagreement with respect to the content of reform, little disagreement with respect to a minimum basket of services, by example, little disagreement with respect to the envelope funding or mechanisms for funding of multiservice agencies. There's no disagreement about the concept of centralized access to services, although there certainly is disagreement with respect to the model which the government has put forward regarding centralized delivery of services.

One of the issues that the government has identified as a requirement for the centralized delivery of services is cost savings and administrative efficiencies that could be found given a system that brings together various agencies that exist now, ie, puts them out of business, and where one centralized administration then would provide all the service.

Much of the argumentation for the government's proposal, and particularly with respect to the cost and administrative efficiencies, was included in an exhibit which was presented to the committee on, I believe, August 31, 1994, by the Senior Citizens' Consumer Alliance for Long-Term Care Reform, an organization which has done an enormous amount of work in the long-term-care reform debate and has participated in extensive consultation on the issue. The consumer alliance commis-

sioned a report, as you know, that was presented to the committee, from Price Waterhouse, which was dated August 31, and was included as a significant part of the alliance's presentation to the committee.

The report indicated in the first part, and I'd just like to quote from it as follows: "This report was prepared at the request of the Senior Citizens' Consumer Alliance. The objective of this report is to estimate the impact of the implementation of the multiservice agency model on the funding available for service provision to clients requiring community-based long-term care. The objective of this report is to estimate the economies that could be realized through integration of case management and service delivery of the various community programs and service organizations into the multiservice agency." That's the conclusion of that quote.

The report undertook to involve and bring into effect several assumptions with respect to the administration and other non-client service budgets which could be redirected to client service under the MSA structure, and the conclusion of that report was that, "Assuming that all other spending levels remain constant, the funding available for service provision"—I add the word "would"—"increase by 25.8% under the multiservice agency structure."

That report, as you know, became a major part of the background and backup for the government's argumentation with respect to the validity of the particular delivery model which it had put forward, and you will understand that our argumentation was that communities should themselves determine which model of delivery was most appropriate to meet their own needs, that in some communities the government's model might be appropriate and that in other communities other models would be much more appropriate in terms of meeting service needs.

Latterly, we received a copy of a report from KPMG Management Consulting which commented on the earlier Price Waterhouse report, indicating that, "In our opinion, Price Waterhouse's assumptions with respect to direct and indirect service costs are not consistent with the approach taken by Ernst and Young, nor with generally accepted financial management reporting practices."

You will recall, Mr Chairman, that the government indicated that it would continue to rely on the earlier Price Waterhouse report and that its conclusions with respect to the validity of its delivery model, of its inflexible template, were based in large part on the argumentation included in the Price Waterhouse study.

Today it's come to our attention that Price Waterhouse

has written a letter, and I would like to read into the record this letter, dated November 15 addressed to Mr Ted Ball of the Senior Citizens' Consumer Alliance. It reads as follows:

"Dear Mr Ball,

"Several concerns have been raised about the approach followed in our report for the Senior Citizens' Consumer Alliance titled A Comparison of the Administrative Component of the Current and Proposed Home Care Systems in Ontario dated August 31, 1994. Our firm is withdrawing the report. We will review these concerns and reissue the report with appropriate changes to the cost-impact methodology.

"Yours very truly,

"Neil Stuart

"Partner."

Mr Stuart, as you know, is well respected in health care consulting, and for him to take this unprecedented step of withdrawing a report placed by his management consultancy organization is one that we find quite extraordinary. We find it particularly extraordinary since there has been so much credence provided to that report in the course of our debate and discussion with respect to the unfolding of long-term-care reform.

We believe that the privileges of members have been breached as a result of information that was incorrect. We find the action of Price Waterhouse in "withdrawing the report," using its words, to be unprecedented and we believe that the original report ought to be ignored in terms of the discussion and debate which is taking place, particularly with respect to the shaping of the agencies that will deliver long-term care and of those other surrounds respecting that, including the 80-20 rule and including the time lines for integration of the new system within a reformed long-term-care system.

1540

We're asking that you indicate to the committee that the earlier report should be ignored and should not be given accountability, and to determine whether, in your view, the committee in fact has been misled by the content of the original report, which would have led each of us to quite different conclusions than a revised study might lead us to.

With that, I conclude my point of privilege.

**The Vice-Chair:** Thank you. May we have the copy of the letter?

**Mr Jim Wilson (Simcoe West):** May I comment on the same point?

**The Vice-Chair:** Yes. Mr O'Connor is the next speaker who asked to speak, and then you're next.

**Mr Larry O'Connor (Durham-York):** Though I'm sure that my colleague across the way here thinks that this is probably what she sees as the reason to hold up long-term-care reform yet again, long-term-care reform has been a process that we all know has been talked about for well over 10 years and we're really, whether or not my colleagues from across the floor want to acknowledge it, the first government to actually act on it.

When the report actually came to the committee, it

certainly wasn't one of the first pieces of information that the committee received.

While we haven't got a copy of this letter that my colleague has quoted in the House and again here in committee, I wonder, where were my opposition colleagues when we had over 300 seniors here who came from all parts of the province, the real consumers who want to receive long-term care, the people the legislation is all based on and developed for? Where were they? It's frustrating to no end to see the lengths that they will go to to try to delay this.

The bill itself certainly isn't something that evolved overnight. There were many reports that were written by previous governments, and in fact this government. If they want to think that this report is the reason that the whole legislation developed the way it did, I disagree. The bill was introduced into the Legislature on June 6 this year, long before this report was ever written. The committee hearings started the weeks of August 15 and 22 and September 13. We've had three more weeks after that where we've been dealing with the reform process as it takes place.

Though this has certainly been one area that we've had some disagreements on in this committee, one thing that we can't ignore is that the reason the reform is taking place is for the consumers. It's for the consumers who have been asking for one-stop access, some local accountability, a well-funded system and one that's going to provide the necessary services in an integrated fashion that hasn't been there in the past. While change is always difficult, change certainly isn't something that either of them offered as a solution. We had 1-800 status quo, which is, "Continue on with everything we've had in the past, only we'll put a 1-800 line in there," which reforms nothing but does something. It doesn't really get to the root of the reform that needs to take place.

My Liberal colleagues haven't even come into the committee with anything other than a brokerage model that they profess as a panacea that's going to solve all the long-term-care problems—

**Mrs Sullivan:** A point of order: I'm asking the member to correct his record; he's quite incorrect.

**Mr O'Connor:** —long before we ever got to the point where we're at today. As the committee hearings have proceeded, we haven't seen any substantial difference from what they had proposed a long time ago. I'm just going to have to disagree wholeheartedly. I don't think she's even got a valid point in bringing this forward.

The legislation we have been dealing with was introduced on June 6, long before this report was presented to the committee. I don't, for what my colleagues opposite are complaining about, support anything they suggest. The fact of the matter is that they disagree, they fundamentally disagree with the government on the reform process as we've defined and laid it out, as amended by the people of the province of Ontario who came to the committee and made suggestions. Unfortunately, they disagree, and that's part of the committee process.

It seems to me that this is just another process of

trying to delay it so that the reform, which has been in the works for well over 10 years, is delayed yet further again.

We've had to no end a number of people trying to discredit the consumer groups that have made presentations to this committee, some of the consumer groups in fact that came to us as members and made presentations to us as members. Whether they want to listen to them or only listen to the providers, that's their own prerogative. But it certainly isn't the avenue the government is going to go down, the avenue of listening to only one side of an argument and having no reform take place at all, which seems to be the case they've got, that they don't want to see the reform take place, they don't want to see the reform continue.

Mr Chair, in your ruling on the supposed point, I would suggest that since this committee has been dealing with this since the bill was introduced on June 6, there is no valid point in what she is suggesting, other than that the information was provided, that there is some additional information. We can thank her for having the additional information provided to us and we can take that under advisement.

The fact that they disagree wholeheartedly with the legislation isn't going to change as a result of this correspondence or anything else that we may receive in the future. I find it frustrating to no end that when we finally get to the point where we're going through clause-by-clause deliberations of the legislation, we haven't even got past the 13th section.

**Mr Jim Wilson:** I appreciate this point because I think what we've seen today is a historic move by a reputable accounting firm—or an accounting firm that is now restoring its reputation with this committee—Price Waterhouse, an unprecedented move, withdrawing a study that it had done for one of its clients that was presented here in good faith. We're not discrediting the seniors' consumer alliance or consumers' groups. It is cheap politics to say that. We have never personally attacked these people.

We have attacked the Price Waterhouse report, and now the authors of that report are withdrawing it publicly. No amount of rhetoric from the government side can downplay the significance of this. Certainly in my 11 years in political life around here and in Ottawa, I have not ever heard of an accounting firm withdrawing its own report, especially a report that received such high-profile attention as this one. It is very, very significant, and not only does it cut to the core of the government's *raison d'être* for its model of reform, because the government has argued, it has used the Price Waterhouse study as a basis for trying to convince legislators and the people of Ontario that their MSA model, the NDP MSA model with the 80-20 rule, is a cost-effective way to reform the long-term-care system.

Today, Price Waterhouse is saying that this is not necessarily the case and has withdrawn its report. So I call upon the government to suspend these clause-by-clause hearings—it's only fair—until the government comes up with its own cost-benefit analysis, because you can't keep going around saying this is going to be a

better or more cost-effective system that provides more service to front-line consumers when now your only piece of evidence has been withdrawn and all other evidence submitted says that your model is wrong.

I reject what Mr O'Connor has said, in that it's been 10 years of long-term-care reform and we're trying to hold that up. The long-term-care reform that we've talked about for 10 years is not the MSA model and the 80-20 rule put forward by the NDP. That's something that's been put in the last 10 months of NDP rejigging with sincere reform efforts that had been going on over the past decade.

1550

**Mr O'Connor:** That's right. We listened to the consumers that you ignored.

**Mr Jim Wilson:** Well, it's time you started to present some facts and that you not do scaremongering and that you try and take a responsible approach to this legislation. Your only base for proceeding in the way you're proceeding has been the Price Waterhouse report. The authors have withdrawn it. I think it's incumbent upon the government to take some responsibility for this process and suspend clause-by-clause hearings until they come back with their own cost-benefit analysis, because it is blatantly unfair to consumers, to the people of this province and to your fellow legislators here to ask us to endorse legislation or to continue to try and amend the legislation in this committee when the basis of your whole reform and the cost-benefit analysis of it is non-existent. And that's just clearly, clearly unfair.

I would have argued, since it wasn't a government report, that this wasn't a breach of privilege to a member. But because the government has used that report, because the unions that presented here have used that report, I asked very specifically one of the unions—I think it was OPSEU; it was Syd Ryan, actually—"On what basis do you make the claim that the MSA model as proposed by the NDP would be a more cost-effective system with less administrative dollars being used up?" and they pointed to the Price Waterhouse report.

Since that report was entered into evidence here, it's incumbent upon the government to, as I said, take some responsibility and come forward with its own figures. Today we've had the auditor's report. I can tell you, in my opinion, if the auditor was allowed to look at this process, and given what I've seen in his report today he would absolutely agree, I would think, to shut you down. Here you've got an accounting firm saying, "Well, I think we were probably wrong," and that's the story. These firms don't do that lightly, and you can't undermine or try to downplay the significance of what's happened here.

I think the government is misleading the public, to continue to go around without any evidence, not a shred of evidence to say that their system is better and not even, you know—in an argument one would, you'd think, be able to bring forward some sort of evidence that their system is better. Instead, we get this rhetoric about 10 years of reform.

You know, there were 10 years of very sincere effort. You people have messed this up, and yes, I and my

colleagues in the PC caucus do reject your model of reform and we're doing everything in this committee to try and modify that model. I hope their next move—because they're not hearing good news out there because they're just wrong and they won't admit it—is that they'll probably bring in closure on this committee. So before that happens, I'd ask the parliamentary assistants representing the government here today to suspend clause-by-clause—I would agree to that motion—and come back to us next week with their own study that gives us some real figures on how dollars will be saved. It flies in the face of history in this province that bigger is better. Bigger, monopolistic, bureaucratic models have not proven to be cost-effective.

To date, once again, we're seeing an admission that even an accounting firm that was paid \$6,000 to try and give the government what it wanted to hear today has to admit in the face of all the evidence that it was simply wrong, and the evidence is not there to support the NDP's contention that this is a more cost-effective model and that it's better for the people of Ontario.

**Mr Paul Wessinger (Simcoe Centre):** I think I'd first of all like to start off by saying that I don't think it's unprecedented that reports by auditors sometimes are criticized on the basis of the methodology they use. I suggested in many instances that accountants or management consultants have to review their methodology, and I think that's basically what the letter says, that they have concern about the methodology. So I suggest there's nothing unprecedented here. This, you must remember, is not a government report. It's a report given by one of the presenters.

Secondly, I'd like to point out there's nothing in the letter from Price Waterhouse that says the report is false or that it contains false information or a false conclusion. It merely states that they're concerned about the methodology used in cost impact, which may question the weight of the report, no question about that, but it doesn't expressly state how it affects the conclusions.

Thirdly, I'd just like to reiterate that this report is evidence before the committee. It's not the basis for the government's policy decisions. I would therefore suggest that the members' privileges have in no way been breached. We listened to presenters many times bring reports before this committee, give evidence, give reports based on certain methodology. I think if we analyzed the methodology of many of the presenters over the years before parliamentary committees, we'd find a lot of faults in the methodology used.

We should remember this is merely a report by a presenter. People are entitled to take whatever they wish, to give whatever weight they wish to any presenter's presentation, and this merely relates to the whole question of how the members are prepared to consider that report. So I just reiterate that it's not a government report. It is not the basis of government policy.

**Mr Cameron Jackson (Burlington South):** Perhaps I'm taking a different look at this letter. Before I comment on it directly, though, I wanted to apprise Mr O'Connor. He said that all we want to do is delay or stop this reform. I want to indicate that although we've read

into the record the article and the statement by Lyn McLeod that she would stop it, I want to underscore this: We did not, under any circumstances, wish to stop the process of long-term-care reform.

**Mr O'Connor:** That's what you said yesterday.

**Mr Jackson:** No. Mr O'Connor, this entire bill is not hanging on 15 minutes of debate in this room. There are far more important things at stake—

**Mr Jim Wilson:** Why did you call Parliament back five weeks late if this so urgent?

**Mr Jackson:** First of all, that is why I want to cast what I have to say about this letter in those remarks, because I'm not convinced that what we've learned today is, in and of itself, grounds to bring everything to a screeching halt.

By the same token, we knew there were problems with the Price Waterhouse study. Those people who took the time to check it out knew there were problems. It was just a matter of time before Price Waterhouse found that out. Let's just set it aside that there were flaws in the methodology.

My question is, who established the methodology and who was advising Price Waterhouse? This is a matter which I think is of legitimate concern to the committee. The reason I say that is that I'm reading a letter that's addressed to Mr Ted Ball at the Senior Citizens' Consumer Alliance for Long-term Care Reform. It's not addressed to Jane Leitch who, I understand, was part of the contract with Price Waterhouse, but Mr Ted Ball.

To what extent did Price Waterhouse rely on representations by Mr Ball? And if those have been drawn into question and we have yet to determine if they come from Mr Ball's presentation or their methodology was flawed because they relied on someone else's advice and counsel, it strikes me that the senior citizens' alliance also has relied on Mr Ball's interpretation, negotiation and presentation with respect to this legislation. To me, that's the more serious issue here.

The report which we've seen, and many of us still have copies of it, talks in the millions and millions of dollars in saving. Okay, so we're going to find out it's not \$90 million; maybe it's only \$5 million in saving, or maybe it's \$5 million of more costs up front. That's not going to change the direction that long-term care goes in. What's of concern to me is that the government's final failing argument is that it has built its entire support for this around the endorsement of one alliance where Mr Ted Ball is the central figure in that whole configuration.

In my view, that raises some serious questions. I think that if there's any validity in terms of going back and discussing it, if there's anybody who should really come back to the table to discuss this matter, it should in fact be the alliance, to ask just what promises have been made.

If I were a member of the alliance, I would be absolutely furious and livid that we were dumped a whole pile of last-minute amendments dealing with substantive labour amendments. I'm quite frankly more upset about its implications to women workers who've devoted their adult lifetime towards service for seniors in this province

and who are being treated like chattel and simply discarded. I can't in my wildest dreams believe that Jane Leitch and her alliance would do that to these workers. I can't believe she'd agree to it.

I think it begs the question, "So what?" So the accounting firm's going to go back and they're going to construct a whole new model and they're going to come out and it isn't the \$90-million saving. But I go back to Bill 101. People were relying on—

1600

**Ms Evelyn Gigantes (Ottawa Centre):** On a point of order, Mr Chair: Are we speaking to an allegation of a breach of the privileges of the committee?

**The Vice-Chair:** It's a point of privilege raised by a member.

**Ms Gigantes:** Yes. And is that personal privilege or committee privilege, and should we be speaking to that issue, not doing an historical analysis and a theoretical analysis of people's motives and so on?

**The Vice-Chair:** It's a point of privilege to which we've allowed the member to speak, so I'm allowing other members to speak to the point, if they wish. There are a number of members who have spoken and some who wish to speak. At that time, unless there's a motion, we will proceed to clause-by-clause. However, if there is a motion, depending on what it is, it may be allowed and what—

**Ms Gigantes:** My point of order is to ask the question, if I may, Mr Chair—

**The Vice-Chair:** Yes.

**Ms Gigantes:** —to what are we speaking?

**The Vice-Chair:** You're speaking to the point of privilege raised by Ms Sullivan regarding information that she has obtained regarding this important matter which the members of the committee were not aware of, at least that I was not aware of, although I wasn't here yesterday.

**Ms Gigantes:** Thank you. I just wished to assure myself that I knew what was under discussion.

**The Vice-Chair:** Oh, all right. Sorry, Mr Jackson, have you completed?

**Mr Jackson:** No. I appreciate the indulgence of Ms Gigantes. I appreciate that she was a member of Privy Council when we were doing most of the work on this bill, and now that she's with the committee, perhaps some of these minor historical lessons are helpful to her. So I didn't mind the interjection one bit.

But Mr O'Connor also made reference to the fact that this bill was introduced in June. I've never participated in a bill in my almost 10 years in this building in which so many substantive revelations are coming forward at the 11th hour.

I think that is also implicit in the concerns about privilege, by virtue of the fact that we are hearing, rightly or wrongly, of these 11th-hour meetings with the alliance and with labour groups and with the ministry, that they have been cloistered away and that these kinds of arrangements emerge and we get these kinds of substantive amendments that quite frankly are going to have a devastating effect, not on the life and survival of a given

agency as much at this 11th hour as much as it's going to have on women workers in this province.

Again, that is where I consider the fact that the government tabled these other amendments as also an example of how this committee has been massaged and treated in a fashion which is both inappropriate and unnecessary with respect to seeking long-term reform in this province.

Frankly, I think the question raises more questions about the credibility of the persons responsible for seeking the report from Price Waterhouse and not about Price Waterhouse itself. The letter is addressed to Mr Ted Ball, and I certainly suspect that before we proceed too much further he should be given an opportunity to explain to this committee, to the alliance that employs him, to the citizens of Ontario who constantly are being told that he and Jane Leitch are the main reason why we should proceed with this legislation. I think he should be given an opportunity to explain just what went wrong, what assumptions he with his many, many years of experience in the health care field missed when he sat down with Price Waterhouse.

Rather than delay even for any length of time, since the government has consciously chosen only to allow 20 days of sitting between the start and the end of this session—that leaves us precious little time. Frankly, somebody should be asking these questions because the government still purports to defend what now appears to be the defenceless.

The questions should be: Why did this happen in the first place, and what other assumptions were our well-intended seniors in this province given who are waiting for reforms? Were they given a similar kind of presentation and by whom, and are they about to withdraw some of their support for something, or are they in so far that they find they can't extricate themselves from a piece of legislation and for that reason unwittingly and unwillingly but necessarily have to follow that they will endorse and support this legislation no matter what elements of it now become flawed in the eyes of the public or this legislative committee?

**Ms Gigantes:** We're dealing with information which was put forward in the form of a claim of breach of privileges of this committee. Then we have a suggestion by one Conservative member that there should be a motion—I presume it would take a motion—to suspend this committee's operation and our work on clause-by-clause considering this bill until something like what Mr Jackson seems to be suggesting, which sounds to me like a full-blown inquiry with members of the Senior Citizens' Consumer Alliance for Long-Term Care Reform and Mr Ted Ball, their associate, before the committee. I don't know what form they're proposing here.

Mr Jackson, when I ask if the Chair would remind us what it is that we have on the table before us, is kind enough to say that there are historical references that he'll make which will enlighten me because I haven't been on this committee throughout all its consideration, which is very kind of him. But, Mr Chair, I will take this time to point out to Mr Jackson that when he was a little guy in knee-pants I was thinking about long-term care. He's that

much younger than I am, even though he's been in the House perhaps as long as I have.

When I first came to this Legislature in 1975, long-term care was an issue and it's been an issue ever since, Mr Jackson. This bill is one to which all members of our government have been committed and involved in from the moment we were elected in the fall of 1990, and it will be that way as we pass this legislation and as the legislation is implemented and as for the first time in Ontario comprehensive and consistent services are available in long-term care for seniors in this province and for people with disabilities.

The question before us, as I understand it—Mr Chair, you'll remind us—is a somewhat procedural question placed by the Liberal Health critic which is, have the privileges of this committee been breached? Every other discussion about suggestions of inquiries and Price Waterhouse's reputation and the relationship of the Senior Citizens' Consumer Alliance for Long-Term Care Reform with Ted Ball there, their contractual employee, as I understand it, and the relationship of this report which was produced by Price Waterhouse and transmitted to this committee by the Senior Citizens' Consumer Alliance for Long-Term Care, all these questions really are not the issue which was raised by Ms Sullivan.

The issue that was raised by Ms Sullivan was the procedural question, have the privileges of this committee been breached? To find a breach, you'd have to find bad faith. There has been no bad faith. Nobody has suggested bad faith. In fact, members of the opposition have been sitting there saying there's a breach, saying, "Let's have an inquiry," but saying there's no bad faith: There's no bad faith on Price Waterhouse's behalf; there's no bad faith by Senior Citizens' Consumer Alliance for Long-Term Care Reform. They didn't say that about Ted Ball, so maybe what they're doing by implication is suggesting bad faith on Mr Ball's part, but I certainly don't assume that and I don't think any of my colleagues on this side assume that.

We haven't yet had a motion to deal with the question of stopping consideration of this bill in clause-by-clause. But we may look forward to one by the way things are going here this afternoon, it does seem to me.

**1610**

The question you've been asked is has there been a breach of privilege of the members of the committee because information has been presented which the sponsoring body now wishes to reconsider apparently. I put to you there has been no breach of the privileges of this committee. There has been no bad faith by the presenters. There has been no bad faith, according to the opposition, by Price Waterhouse. I see no bad faith on the part of anybody.

I will repeat what my colleagues have already said, which is that this legislation does not depend on the report which has been raised in question this afternoon. The legislation precedes the report by many months. The report has never been used by our government as the reason or rationale for the legislation, not at all. It didn't exist when the legislation was tabled. Nothing that is before us in terms of amendments is related to the report.

The report was of interest. It will be interesting also to see how it is questioned.

I put to you that your ruling should be—and it should be soon, otherwise the purpose sought by some members of this committee, which is to delay, stall, clause-by-clause consideration, will be met by a failure of our committee as a whole to proceed in an orderly way.

**The Vice-Chair:** It is a concern, the time that is being spent perhaps on this matter. We have other speakers who have indicated they wish to speak, however, and we will proceed with them and ask them to be as brief as possible.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Ms Gigantes has just suggested there have been no charges of bad faith. Bad faith charges are very serious and they won't be placed today. What we are finding very difficult is that there has been no cost-benefit analysis other than this and may I say, since it was tabled on September 15, it has been quoted by several members of the government caucus as the cost-benefit analysis they've hung their hat on. That, in my mind, is quite serious because there's been a continuing stubbornness, stonewalling, whatever you want to call it, when we ever get down to costing of this bill and the cost-benefits of this particular bill.

Almost immediately after the report was presented—and, by the way, I did have the opportunity to question the alliance the day they came in here and the very first question I presented was on the assumptions of the report. That was not any great stroke of wisdom; they were so obviously incorrect. Immediately, we got presenters coming and questioning the report, but in the face of that, we still got government members suggesting that the report had credence and we had them read into the record. I will certainly continue to find that very difficult, that it is the only single costing that we have seen in any shape or form connected with this government, even though we know the bill is millions, billions of dollars in its implementation.

I leave that and I really do feel that somehow or other there has been some inability to put facts on the table that would help opposition members and indeed, the many, many presenters understand the costs of this bill. It's very irresponsible to proceed with a piece of legislation of this breadth without any costing. At this moment, certainly with this report being withdrawn—and I do think it's certainly not ordinary for a major accounting firm to withdraw a report even though it is on methodology. The methodology is assumptions, for the most part, and the assumptions somehow were given, placed, or whatever, incorrectly and that was obvious from the beginning.

Those are my remarks. I place them because I really do have difficulty with the extent of this bill, with no cost-benefit analysis.

**Mr Gary Malkowski (York East):** I think, just to remind the committee members, that we're talking about the point of privilege and whether privilege has been broken. Price Waterhouse is not government documentation or a government report. It was presented similarly as other presenters submitted reports and it's just their opinion.

Our position is to listen to all the presenters. We have to remember that the issue talks about, again, the breaking of privilege and about bad faith, but we believe that nothing was done wrong in terms of the process and that this does not break any member's privilege. Our position is that we were to listen to all the presenters and hear all the opinions. Sometimes presenters innocently have mistaken information, but we listen to everyone.

The second point: opposition members. I think the intention is clear: to stall and delay. Seniors have been waiting for a long time, they deserve this legislation and I think what we need to do is balance the concerns. We have heard the concerns from the service providers, but we also need to listen to the seniors who are waiting for the legislation. So if we get down to the basic question of whether this is a breach of privilege, it is not a breach of privilege.

**Mr Tony Martin (Sault Ste Marie):** I guess I'm both surprised and not surprised at what has taken place here today. Certainly the letter is a bit of a surprise, coming as it does at this late time, but I'm not surprised at the tactic that we're seeing.

Any of us who have been involved in making change in our communities and in this province over a number of years or for any length of time know that a good opposition is well organized and has in its arsenal of approaches to these kinds of issues a number of things that they will present at strategically important times, and that's exactly what we have here today.

It's interesting, on a day when the seniors' alliance and other seniors from across the province have come to this Legislature, to this place, to impress upon us how seriously they see this piece of legislation, how much they want it, how they wait for it and how disappointed they will be if we take much longer in putting it into place, that we should have this letter come to us.

**Mrs Sullivan:** On a point of order, Mr Chair: The member is questioning the motives of other members of the committee, and not only the motives of members of the committee, but the motives of Price Waterhouse itself.

**Mr O'Connor:** No. He just said opposition to the bill. He didn't say your opposition; he said opposition.

**The Vice-Chair:** Mr Martin.

**Mr Martin:** This letter, which is—

**The Vice-Chair:** Just a moment, please. Mr Jackson.

**Mr Jackson:** On a point of order, Mr Chair: This really should be cleared up. I listened to Ms Gigantes's comments very carefully. The point of order here is that we'd all agreed there was no bad faith on the part of Price Waterhouse. I just heard the member suggest that the timing of Price Waterhouse's dropping of this letter is, in so many words, bad faith.

If that's in fact his case, which is what Ms Gigantes said is the whole basis on which we may have a case of privilege, and if he is now suggesting that now we have a member who thinks it, I'd like him to think carefully what he's implying. You can impugn all of us over here all you want, but you're clearly suggesting that Price Waterhouse strategically dumped this today.

**Mr Martin:** Oh, come on.

**Mr Jackson:** That's exactly what you said. Ms Gigantes, I thought, had at least found a consensus on that point. But if it's bad faith on the part of Price Waterhouse, then perhaps we should be reviewing that question. I don't think it is.

**The Vice-Chair:** Mr Martin, do you wish to respond?

**Mr Martin:** Yes. I find the timing of this letter rather interesting, and can only imagine the activity behind the—coming to a point of a reputable organization like Price Waterhouse to have to actually deliver a letter like this, and at this particular point in time. As I was saying, the date on this letter is November 15. It was yesterday. It could have been delivered yesterday, a day before the folks who are with us today weren't here and—

**Mrs O'Neill:** Today is November 15. He doesn't know what day it is.

**Mr Martin:** I'm sorry. Okay. Today's date, yes.

**Mr Jim Wilson:** This is November 15, social development committee, Bill 173.

**Mrs O'Neill:** You're in real trouble.

**Mr Martin:** I made a mistake. I apologize.

**Interjection:** Tuesday.

**Interjection:** Reality check.

**The Vice-Chair:** Proceed, Mr Martin.

**Mr Jackson:** You can't be that lucky; yesterday you were on a plane.

**Mr Martin:** I'm sorry. I guess I'm just anxious to get this piece done, and time is moving rather rapidly for me here. If we don't get it done, I'll be in the position of having to rely on long-term care.

1620

**Mr O'Connor:** If we had to rely on them, you would be for sure, if you had to rely on the opposition to bring it forward.

**The Vice-Chair:** Order. One speaker at a time. Mr Martin has the floor.

**Mr Martin:** If the opposition has its way, that indeed will probably be the case. Anyway, I just want to assure the seniors who are here today, the seniors out there in Ontario who are awaiting anxiously the passing of this legislation so that we can get on with this very important initiative and piece of work, that we as a government are going to soldier on. We're determined to see this through and to see it through in a timely and efficient fashion.

Today, just by way of connection, we had a number of seniors come to this place to again assure us of their continued support for this piece of legislation. They write to us. I want to put it on the record.

"On behalf of the organizations"—that I will list at the end of this letter—"we would like to indicate our support for Bill 173, An Act respecting Long-Term Care.

"As seniors and consumers, we know the status quo is no longer a viable option. Recently there has been an intense campaign against Bill 173"—of which this little piece of action today is a part—"launched by some provider agencies.

"We assure you that our consumer organizations want this legislation passed. We feel it is necessary for the

delivery of appropriate and necessary care which is more accessible to consumers.

"In the current economic environment, our organizations believe that agency amalgamations must be an outcome of this reform. As taxpayers, we want our dollars spent expanding direct services, not maintaining the duplicated administration and management structures created by 1,200 separate agencies.

"While we have concerns regarding the implementation of this legislation, we feel that Bill 173 is the necessary foundation for building a comprehensive long-term-care system of which we can all be proud. Therefore we would once again like to urge all legislators to move forward with this legislation without further delay."

It's signed by the Senior Citizens' Consumer Alliance for Long-Term Care Reform, Jane Leitch; the Older Women's Network, Ethel Meade; Consumer Coalition on Health and Long-Term Care, Patricia Bregman; United Senior Citizens of Ontario, Jack—thanks, Jack; Concerned Friends of Ontario Citizens in Care Facilities, Eleanor Murphy; Canadian Pensioners Concerned (Ontario), Mae Harman; the Ontario Coalition of Senior Citizens' Organizations, Bea Lewis; and the Canadian Auto Workers Retired Workers, Leonard Harrison.

I'd like to get this letter to the clerk to be put as part of the record.

**Mr Dalton McGuinty (Ottawa South):** I was very surprised to see this letter on my desk when I showed up for committee today. This is not of course—the letter makes reference to more than just a study; it is the study which over time began to assume the place of the cornerstone of the government's support for this particular bill.

If we had another study before us, then of course that would lend some balance to this one and we could therefore place less weight on it than we would've placed on it from the outset. But the fact of the matter is, it's the only study that we've received.

We could spend a great deal of time saying how reprehensible it is on the part of the government to advance a proposal that's contained like this in this particular bill without costing it out. I don't want to spend any time on that. Let's try to address the issue raised by my colleague.

It's been said here today that there's only a breach of privilege, that somehow Price Waterhouse has acted in bad faith. I disagree. Our privilege here as members of this committee is to receive the very best information that's available. We require that information in order to properly assess the merits of the bill.

We've been told quite candidly by the folks at Price Waterhouse that they're withdrawing their report. Again, it's the only report that we received.

I suggest to you, Mr Chair, that our privileges, if they haven't already been breached by not having the best information before us, shortly will be, because we're about to act on the basis of information which we now know we should not be relying upon.

For that reason, Mr Chair, I think you have to recognize that there has been a breach of privilege, or

shortly there will be, if we proceed on the basis of information which we've been told we can no longer rely upon.

This is an important issue. I was in my constituency office this morning, and a gentleman walked in off the street to raise this very issue. It's generated considerable controversy. Many people are paying close attention to it. There's concern about the implications, obviously for long-term care in this province, about the future implications. We have to do everything we can to have the very best information before us. If we don't have that information upon which we can rely, then our privileges, indeed our obligations as members of this committee, will be breached, Mr Chair.

**The Vice-Chair:** Thank you. Each member of the committee who has indicated they wished to speak to the point of privilege has spoken, and to proceed further would—except one member has not spoken—be indeed to call upon members who have already spoken. We will now proceed. There has not been a motion presented to be dealt with by the committee. The Chair does not decide on points of privilege but whether to allow discussion on points of privilege and indeed a motion that would be raised from a point of privilege. As there is no motion before the Chair at the present time, we will—

**Mrs Sullivan:** Mr Chairman, I would like to put a motion before the committee:

That the committee indicates that its privileges have been breached as a result of information which was placed before it on August 31 through the Price Waterhouse study included in the Senior Citizens' Consumer Alliance for Long-Term Care Reform presentation to the committee, said report having now been withdrawn with concerns raised with respect to the cost impact methodology utilized in the report.

**The Vice-Chair:** Thank you. The motion is before the committee. Are there any speakers to the motion?

**Ms Gigantes:** I call the vote.

**Mr Jackson:** Can I have the motion read again, please?

**The Vice-Chair:** Thank you. Is someone prepared to read the motion?

**Ms Gigantes:** We don't have it.

**The Vice-Chair:** We will be able to obtain it in writing shortly if we proceed. We have some of it but not all of the wording. Ms Sullivan, would you care to assist or—

**Mrs Sullivan:** Mr Chair, can we retrieve it from Hansard?

*Interjections.*

**The Vice-Chair:** It was a verbal motion which has been presented and read into Hansard.

**Mrs Sullivan:** Could I request a 20-minute recess and perhaps Hansard can play back the tape? Thank you.

**The Vice-Chair:** We have a request for recess and due to the importance of this matter the committee will recess for 20 minutes.

*The committee recessed from 1629 to 1651.*

**The Vice-Chair:** When we recessed we had a motion proposed by Ms Sullivan. Would you clarify the word "indicates," "that the committee indicates that its privileges..."? Would that be to the House?

**Mrs Sullivan:** Yes, to the House.

**The Vice-Chair:** Would you then read the motion once more and make that change please.

**Mrs Sullivan:** I move that the committee indicates to the House that its privileges have been breached as a result of information which was placed before it on August 31 through the Price Waterhouse study included in the Senior Citizens' Consumer Alliance for Long-Term Care Reform presentation to the committee, said report having now been withdrawn with concerns raised with respect to the cost impact methodology utilized in the report.

**The Vice-Chair:** Discussion on the motion? I believe Ms Gigantes had said that the motion be put.

**Ms Gigantes:** I move that we take a vote.

**Mrs Sullivan:** Recorded vote.

**The Vice-Chair:** Recorded vote. All in favour of the motion?

**Ayes**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessinger.

**The Vice-Chair:** The motion is lost.

We'll now proceed to clause-by-clause, and the next amendment was a PC motion regarding section 13 of the bill.

**Ms Gigantes:** Mr Chair, on a point of order: I believe that we had been going—oh, that's right. I'm remembering now.

**The Vice-Chair:** We're in order?

**Ms Gigantes:** Yes.

**Mr Jim Wilson:** I move that clause 13(2) of the bill be struck out.

**Interjection.**

**Mr Jim Wilson:** Sorry, are we doing that one first or are we doing the additional subsection 13(1.1)? Sorry, subsection 13(1.1). I read the wrong motion into the record.

I move that section 13 of the bill be amended by adding the following subsection:

"Purchase of services

"(1.1) Within the approved budget, the multiservice agency shall not be limited in any way in the purchase of community services from other multiservice agencies, service providers, individuals or persons."

Again, this is an attempt, and a very sincere attempt, to eliminate the 80-20 rule, which we think is arbitrary on behalf of the government; it's certainly a job-killer in this province at a time when the rhetoric of the government claims that it's trying to create jobs; it's anti-free

market; it's an insult at its minimum to the people who have been providing services for many, many years in this province; and most important, it is the rule in this legislation that will wipe out these service providers and their jobs.

This section, in addition to the labour amendments that are being put forward by the government, spells the death knell for not only commercial agencies in the private sector, but for the VON and the Red Cross and Saint Elizabeth visiting nurses.

It's the most problematic part of the bill. It's something that we simply can't tolerate. It's something that did not come from consumers, as the government claims. It is simply that the NDP's ideology worked its way into this legislation and, as a result, they came up with this 80-20 rule. We've had quite a bit of debate on it, and it just surprises me, actually, that the government won't budge on this.

I even note something I wanted to mention yesterday and didn't have the opportunity, that two of the presenters who seemed to be in favour of the 80-20 rule, who were Dr Rachlis and Carol Kushner, even they talked in their presentation about the need for competition in the system. They say, on page 4 of their brief to this committee on October 3 of this year, "We have some concerns that...an absence of competition among MSAs could stifle innovation instead of promoting it. To avoid this, we recommend that the regulations allow different MSAs...to compete with each other."

It goes on to say, "We suggest that the province publish routinely outcome information" about MSAs and how they're performing and that sort of thing. So even they, in their recommendations to the committee say that there should be some element of competition in the system. While they argue in favour of the 80-20 rule, they somewhat counter their own argument by saying that even monopolies should be able to compete among themselves between geographic regions. I think logic failed them, but they did attempt to convince this committee of the 80-20 rule.

Really, when I think of it, they are credible people in our society. They're often listened to by governments, but even they failed to convince me and my colleagues that the 80-20 rule is a necessary part of long-term-care reform. They talk about very clearly competition which exists with our current brokerage system. I think it's an insult, and we heard some of this in the debate earlier today, when it's suggested that long-term-care reform has been on the table since 1975. Implied in some of the statements coming from government members is that nothing's happened in the last 19 years in this province.

That is an absolute insult to not only our predecessors in this Legislature who worked very hard, ministers of Health from Conservative governments and Liberal governments, including the NDP, who extended the integrated homemakers' program, to say that nothing's happened in 19 years and that we have to put through this type of NDP reform now, which is clearly wrong, which is not supported by—the only study that was out there has been withdrawn, so there's no support for the government's underlying premises of this legislation in

terms of the cost-effectiveness and really the future direction that the government wants to go.

To listen to the government it would be that seniors weren't served well over those 19 years, and yet I've consistently said, since the beginning of these committee hearings, "Bring us forward evidence that the VON's not doing a good job or that the Red Cross is not doing a good job or that Saint Elizabeth visiting nurses are not going a good job or, for that matter, that Para-Med's not doing a good job and Dynacare and other players in the system."

If you're going to radically reform the system in your own image, it's incumbent upon you to make a case. You've just failed every test, and today they pulled the rug right from under you in terms of the only thing you could hang your hat on was the Price Waterhouse study and now it's gone. Puff. It's just gone.

So we're left in an absolute void of any evidence that what we're being asked to do is good except that we're told there's an urgency to get this reform through and that all of that great history in this province should be dismissed and that we're to accept this evil in the name of expediency.

This motion attempts to get rid of the greatest evil in this bill, which is this arbitrary 80-20 rule to wipe out service providers who have been doing a very, very good job in this province. While there were some problems with coordination, they could be fixed without legislation. That is the conclusion I've come to. In many areas of the province, those service providers are working together to ensure that there's a single point of access, to ensure that information is available to seniors and ensure that the system is generally easier to understand and access.

1700

They want to wipe out the experts, and in their process of wiping out the experts they also exclude other people who are in elected offices, like municipalities, and, by extension, boards of health. The reason they do that is because, as I've said earlier in these hearings, there is no way the municipal council people whom I know, including many who are now newly elected, if they truly understood what the government's MSA model is all about, they would play ball. There's no way they would implement this in my county. We're already told in Metro they wouldn't do it.

The government is just wrong, wrong, wrong. I think we have a moral obligation in opposition here to not only get the government to try and see the errors of its way but to do everything we can to make sure that if the government is hell bent on proceeding with its model, we make commitments.

Certainly the commitment of my party is that if we form the government in seven months or eight months in this province, we will undo the 80-20 rule. It will be repealed. The only good news I can share with the people of the province is that I expect this government will be booted out of office; that this, along with a myriad of other things that it's tried to do over the last four years, will be rejected by the people of Ontario and that the next government can repeal things and can fix things.

I guess we probably all get this in opposition; I get it at home with respect to Bill 40, the labour laws, and other things that we're committed to repealing. People say: "Well, how do you do that? Jeez, it's the law of the land." We want to make it clear that a law that's made one day can be undone the next day. I think the government does a disservice to the people of Ontario, knowing that opposition parties are committed; that whatever one forms the next government, we will change this 80-20 rule.

So why is the government doing it now? It has no mandate from the people, as I said at the beginning of my remarks. Consumers, when they truly understood this en masse, did not ask for this. This was not part of the original package or deal or discussion with the people of Ontario about long-term-care reform. I think they just want to do it because they want to get up at all-candidates meetings and say to the very few union friends they have left that they had "the courage to do this." That is the language they use.

They're trying now through the health sector, which they've tried desperately to do since social contract days with other sectors, to just get back those few union votes. Certainly when we get to section 15, we see new amendments which very clearly will ensure that people who are non-unionized now in the community-based sector will not have a job in the MSA and that regardless if somebody might have 20 years of service as a non-unionized nurse in the community-based sector, they will have to wait in line for a job with the MSA behind someone who might have as little as two years of service as a unionized nurse in the community-based sector. The question of fairness there is absolutely mind-boggling, how the government can do that.

I want to just make sure the government understands who is in favour of removing the 80-20 rule. In the summary of the recommendations that's provided by legislative research with respect to this section, it reads: "Remove limits on the amount of services that an MSA may purchase and enable each community to choose the best service delivery model(s) and optimum mix of provider agencies to meet the needs of its residents."

Before I read out all the groups that are in support of that statement, I just want to say that what's been lost in this debate and what I felt was shameful about today's activities by senior representatives who were here is, I didn't hear much about consumer services and front-line services. I heard a lot about, "Well, we're going to be given positions on district health councils." The minister very clearly said that in the House in response to a question today, that there's been a bit of a tradeoff with the CAW retirees that they'll be allowed to sit in part of the planning process on district health councils.

To me, and I've said this many times, we are killing ourselves with political correctness in this province. We are so caught up over the last four years—and I shouldn't say "we," because I'm not caught up in it. While consumers must be allowed to participate in the decision-making process—

**Mr Wessinger:** On a point of order, Mr Chair: My point of order is that the member is making statements

that are inaccurate with respect to the effect of the labour amendments. We have legal counsel here and I think they should clarify the situation to the effect of the labour amendments as they relate to the status of non-union employees. The member is making the representation that non-union employees will lose their jobs as a result of these amendments, and that's completely inaccurate.

**Mr Jim Wilson:** It's not inaccurate.

**Mr Wessenger:** It is inaccurate, and if you'd read the amendments you'd understand that. I would ask that—

**Mr Jim Wilson:** That's not a point of order, and I have the floor.

**Mr Wessenger:** It is a point that you're making—

**Mr Jim Wilson:** It's your opinion, which I strongly disagree with.

**Mr Wessenger:** I know you're afraid to have the legal staff here clarify what these amendments mean. If we're going to discuss this matter, we should at this time have them up here to explain the impact on the legislation. Otherwise, I suggest we leave this matter to be discussed and you leave your misrepresentations out until we get to deal with these items in section 15.

**Mr Jim Wilson:** Fine. That's your opinion, Mr Wessenger.

**The Acting Chair (Mr McGuinty):** Mr Wilson, please continue.

**Mr Jim Wilson:** It's your opinion. I don't agree with it. A number of groups don't agree with it, and when we get to section 15, you can make that argument all you want.

With respect to needs of residents, needs of the people of this province, residents of this province, I think those front-line services are being neglected in much of this debate. Clearly, the model that's set up with an 80-20 rule says that you will have more expensive multiservice agencies. With an amalgamation of agencies, it will be more expensive. We'll debate section 15 when we get there, but particularly with that thrown in, you're going to have very expensive service providers providing less service, unless the government comes up with even more money than it says it's putting into this sector—and they won't even give us those costs.

We keep hearing figures of \$600 million or \$650 million. We heard that during Bill 101. When we went to estimates, we couldn't find the evidence for that. We could find some money transferred out of the institutional side into the community-based side, but when we actually had the minister in front of committee, we found out that this was a lot of smoke and mirrors, that those figures didn't hold up, and that much of that money came out of new user fees on the institutional side.

But the government again won't put on paper for us to see any type of cost-benefit analysis, so we have to go on what we've been told.

Now that the Price Waterhouse study has been withdrawn, we're left with estimates such as that one provided by Saint Elizabeth visiting nurses that said the NDP's MSA model would be \$7 million in additional nursing costs alone in Metro Toronto, or a figure that we

worked very hard to come up with, and that is with respect to the loss of volunteers, which is all part of the 80-20 rule.

The loss of volunteers, the fund-raising dollars, the volunteer hours that are given to this system now from the hearts of individuals of this province: Our figure is, at a minimum, \$37 million.

We look, as we said in the Legislature yesterday, to the province of Quebec, where I met publicly with Russ Williams, the former parliamentary assistant to the Minister of Health, four weeks ago in Montreal. He very clearly said to me and to the Canadian Drug Wholesalers Association in a public meeting that, "Yes, we," meaning the Liberal government of Quebec, "killed volunteerism in the province of Quebec," and he regretted that aspect of the policy they had introduced, which was a similar type of monopolistic, one-stop-shopping model that the NDP is embarking on.

With respect to support for removing the 80-20 clause, and the statement I read a couple of minutes ago, it was presented to this committee and supported by the Canadian Red Cross Society, Ontario division, the Thunder Bay and northwestern branches, the Sault Ste Marie branch; the Ontario Community Support Association, Nipissing and Sudbury, areas 4 and 15, the Hamilton branch of that association; the regional municipality of Sudbury; the Canadian Red Cross Society, southwest region and Windsor branch; the Canadian Red Cross Society, west central and central regions; St Joseph's Health Centre of Sarnia and London; United Way of Greater Toronto; Ontario Dental Hygienists Association; United Way of Greater Toronto—I think I just said that; Saint Elizabeth Visiting Nurses' Association; Hamilton-Wentworth and Halton Canadian Red Cross societies, also the Ottawa branch; Ontario Community Support Association, area 10; the All-Care Health Services; Canadian Red Cross Society, Quinte branch; Community Support Coalition of Ottawa-Carleton; Ontario Hospital Association and Council of Chronic Hospitals of Ontario; the city of Toronto long-term care negotiating committee; the Ontario Association of Non-Profit Homes and Services for Seniors; and the Victorian Order of Nurses, greater Toronto area.

1710

With respect to the following statement, the recommendation with respect to section 13 was to delete this section, the 80-20 rule. It says, "The local community should decide which is the most efficient and cost-effective way of delivering services to ensure choice, quality, growth and cost-effectiveness." That came to us from the Ontario Home Health Professionals.

"Eliminate the 20% limit and allow each community to set its level of outsourcing of services. The guidelines to determine such services should include (a) the cost of service; (b) the quality of service; and (c) the waiting list for services delivered by the MSA." That was the advice of the Haldimand-Norfolk Transitional Steering Committee.

"Eliminate" section 13; "instead, a more flexible approach should be identified in the regulations or approved in a contract with the board which is reviewed

regularly." That was put to us by the Ontario Home Care Program Association.

"Delete" section 13, referring to the 80-20 rule; "each community must be allowed to determine the appropriate mix of service." That came to us from the regional municipality of Ottawa-Carleton, the United Way of Peel region, the Hamilton-Wentworth District Health Council.

It was recommended that "there be increased flexibility in the percentage of services to be contracted out by MSAs. The percentage should be responsive to the needs of local communities and be determined through planning in DHCs." Now, that would be somewhat of a compromise, if you wanted to consider that, government, from total elimination of the 80-20 rule, but to allow a flexibility in the percentage of services. That was presented to us by the Council for Aging in Ottawa-Carleton.

"Recommend that the 20% limit be reviewed and revised to allow for a greater involvement of other service providers. If it is necessary to maintain this limit for mandatory services, these should be developed on a service category basis and should not be similar for all types of services." Again, a compromise saying the 80-20 rule shouldn't be rigid throughout the range of services and the geographical areas of the province. That was put forward by the Older Adult Centres' Association of Ontario.

"Amend to eliminate the restriction on purchase of service and to redefine the mandate of MSAs as being to provide service coordination with the possibility of a variety of locally determined service delivery models." That was put forward by the Home Care Program for Metropolitan Toronto.

"Amend to give MSA administrators the power to purchase unlimited services, on a contractual basis, from any service provider." That was presented by the Nightingale Nursing Registry.

An individual by the name of George Farnham, with respect to the adverse effect this 80-20 rule will have on commercial providers, said delete the 80-20 rule; "the private sector must remain in the delivery of services."

It strikes me, Mr Chairman, that when you consider that about half of the home care services in the province now are delivered by the private sector, I have no idea how the government in even a four-year time frame, without millions and millions and millions of additional dollars strictly going into administration and startup costs, can begin to fill the gaps in services it's going to create. I mean, it's just mind-boggling. They're right; the government is right. No government has ever had the courage to do something that stupid. That's true. That's very true.

What they're doing there with respect to commercial providers is exactly what we've seen them do in the child care sector. Estimates are around \$100 million in recent years to simply drive private sector child care operators out of business, and they've done a heck of a good job. This came from the government itself. If we look at from about 1986 to the present, in 1986 we had 1,216 non-profit child care agencies delivering service in the province and 1,039 private; relatively balanced.

**Mr O'Connor:** What section is the child care?

**Mr Jim Wilson:** The 80-20 rule is the same thing you did in child care in driving out commercial providers. You go further in Bill 173; you drive everybody out of business, which is really astonishing when you think about it. But in 1987 again we had roughly a 50-50 mix, but we began to see a preference towards the not-for-profit sector. We end up in 1993 with 2,441 non-profit providers and just 595 private sector providers. Again to that, for that \$100 million—and there were some additional dollars put into spaces—we are told that was strictly spent on converting people from private sector day care to not-for-profit.

**Ms Gigantes:** No.

**Mr Jim Wilson:** You can deny facts. They've been brought up in the Legislature many times, where your minister has not denied the facts from time to time.

**Ms Gigantes:** A hundred million dollars? Give me a break.

**Mr Jim Wilson:** Well, I mean, the other figure used is \$200 million. That one I dismiss because I can't support it in the estimates.

Let me tell you how that works. I just want to put this plug in for the commercial providers. I deserve to do this because the minister yesterday, in response to my question, totally twisted anything that my party might have said. She said we're out to privatize health care. I actually heard this on a cable show I was on in Toronto two weeks ago from Ms Caplan. It's a complete misrepresentation.

We don't think you should have an 80-20 rule; we don't think you should have a 10% rule; we don't think you should have any rule. The market should decide. Consumers should have choice. In my area of the province, I'm confident the Red Cross and VON will continue to provide great services and they'll compete with the private sector, as they're doing right now. As a result, they have 100% of the market share in one area of services and 97% of the market share in other types of community-based services.

That's fine. That's great. That was done because that's what consumers wanted; it's what the market dictated in Simcoe county. Private providers weren't willing to go up there because I think they would argue that the economy of scale and the market wasn't such that they could do well in that area. So we have other agencies, agencies where now you want to wipe them all out.

We have a policy that always was the policy of this province prior to 1986, when the Liberals brought in amendments to the Independent Health Facilities Act where we saw this bias against the private providers and towards the not-for-profit sector. Again, no cost-benefit analysis done back in those days, but there was money around in those days and if you wanted to have that bias, you could probably afford it if it cost more money. Our policy is simply not to have any arbitrary—because where would you draw the line? Anywhere you draw the line, you're doing some social engineering in the province; you're ignoring market forces.

So the minister, while it was politically expedient for

her to misrepresent our position in the Legislature this week, clearly was wrong. We've never said, "Privatize this area." We simply said there has to be healthy competition and that we can't have programs like we saw in the day care sector, where money is simply wasted shifting the sector from a balanced to an ideological approach.

The famous day care story I have is that in my own riding I have one private sector day care provider who has held out against all of the generous offers made from the government under its non-profit conversion program. The woman who owns the day care never made any more than about \$18,000 a year running this day care in my riding. She was quite happy doing that, quite happy. The capital costs, she paid for. It's run as an extension of her house. I think there were about 25 children in it at one time, at its peak. She called that her salary. The government said that's a profit on the backs of children. But she was quite happy and it turns out to be cost-effective. They have, through their program, approached her so many times it's getting sickening to say: "Please convert. Please convert."

1720

Now we've changed the law so that any children who are subsidized now, the subsidy must go to the not-for-profit sector. So they're trying to kill the commercial providers there by, really, expropriation or attrition of services. But they've said to her: "Not only will you make more money in your non-profit day care because you can guarantee yourself a salary, but you can also hire a couple of assistant executive directors. So you can become the executive director of the new non-profit day care."

We'll even pay for the sign change out front and you can hire a couple of assistant executive directors. Just at the end of the day, whatever happens—plus, all these subsidized kids will now be able to come back to your day care—just don't make a profit, but absorb it in salaries if you have to."

It's a crazy policy, and that's not one the VON and Red Cross and so on buy into. I don't think they have done any of those shenanigans. I know a lot of these people personally. They don't want the 80-20 rule. They're ready to compete. They've got 75 years of history in the Canadian Red Cross and they're doing a good job.

Another group that wanted us to delete the 80-20 rule said: "This restriction will have an adverse impact on commercial agencies; many will go bankrupt and consumer choice will be limited." That was the Ontario Home Health Care Providers Association, Comcare (Canada) Ltd and Bradson Home Health Care.

Concern was expressed that the "private sector businesses which were established to provide care to palliative care patients will be forced out of business by the 20% limit and patients and their families may suffer as a result." That concern was expressed by the Ontario Palliative Care Association.

"Support a mixed approach of not-for-profit and for-profit agencies and oppose a strictly not-for-profit

policy." That was put forward by York Region Home Care Program, the Senior Citizens' Consumer Alliance for Long-Term Care Reform, Ottawa branch, which is surprising.

We had many, many other groups whose comments, if time permits, I will read into the record, but there are more amendments coming up dealing with this section. I just, at the end of the day, don't know where the government gets its gall in asking us to support this section of the bill when there just seems to be no logical argument that you can put your mind around to justify its existence. As I said, it is the provision of the bill which, coupled with the labour section, allows for one-stop unionization. We've had our lawyers look at that argument, and indeed we're right. We had the Christian Labour Association, the third-largest union, appear before the committee and say that this bill would indeed increase the rate of unionization in this sector.

The 80-20 rule does what Bill 40 couldn't do. On Bill 40, and that's the NDP's labour laws, during the committee hearings we had a lot of groups come forward and say they have a real difficult time organizing what they call "scattered" workers, and those are workers, literally, who are scattered throughout the province, maybe only one or two people in the shop providing services. Bill 40 didn't go, in some people's opinion, the NDP's opinion, far enough to make it really easy to organize scattered workers. So what this bill does, through the 80-20, by putting all of your unionized and, prior to seeing the government's amendments this week, non-unionized workers under the MSA, is make it extremely easy to unionize the whole shop.

**Mr O'Connor:** Point of order, Mr Chair: My colleague is talking about the labour amendments again.

**Mr Jim Wilson:** No, I'm talking about the 80-20 rule.

**Mr O'Connor:** The honourable parliamentary assistant did offer to have the staff clarify some of what his concerns are, if he wants to speak to that. He's talking about labour amendments, and if that's what he wants to do, that's fine, but he's been certainly going on at some length to this point and talked a range right up to day care. I just wondered if maybe he wants to have the staff address some of the labour concerns that he himself is raising in his talk right now.

**The Acting Chair:** Thank you, Mr O'Connor. I will indicate that Mr Wessinger has asked to be put on the list, so he will be addressing that issue, I assume, and others. Please continue.

**Mr Jim Wilson:** You know, I am addressing the 80-20 rule. The only reason I can see it's in there is this one-stop unionization. It doesn't speak to better services, because we know there are going to be tremendous startup costs at least for these MSAs in getting up and running, so the scarce health care dollars we have out there are going to be directed towards new bureaucratic administrations. Who are the losers but the seniors of this province? Their numbers are growing every day.

If we lived, I suppose, in a Utopian society where money grew on trees, I don't think we'd be that concerned. Nobody would be that concerned. If the govern-

ment wants to go and unionize a sector, fine. If the government wants to put everybody under a monopolistic roof, fine. But we have very limited dollars and we can't afford those dollars, through the 80-20 rule, going to beef up an ideological agenda. I can't picture a consumer in this province who can't see that that's what's happening, that like almost every other piece of legislation—and you know, they should take our word for some of this because we've had four years of experience with this government—this has a hidden agenda.

**Interjection:** You've ignored every consumer group that's made a presentation.

**Mr. Jim Wilson:** Even social contract didn't save any money. We're already trying to figure out how we're going to deal with the cost hit we're going to take on March 31, 1996. We know Metro Toronto's budgeting half a billion dollars that they're going to take because they'd didn't save any money on emergency services and ambulance and fire.

In hospitals where the regular staff nurse has to take the day off but you have to bring in an agency nurse from a private sector firm for time and a half, where the heck's the savings?

No, the hidden agenda there—and Michael Decter said it himself—was power-sharing. If you thought social contract was about money, you were wrong, you missed the boat, he told the conference. It was about power. Now we have all these sectorial committees of unions. I don't know how a minister could possibly make a decision any more in this province. You've got to go through layers of new representation that's been put there under deals and side deals made under social contract.

Every bill, practically, has a hidden agenda to it. The not-so-hidden agenda on this one, I guess now, is this one-stop unionization. I think it's the seniors of this province and the disabled—and we don't even know where children fit into this legislation; we tried to do that in earlier amendments.

The people of this province are the losers. The people of this province are the losers when the next government has to undo some of this, because that costs money. It takes legislative time, because unlike the 10% rule of last year, which was done by cabinet through policy change, they're actually putting this 80-20 rule in legislation, so the next government can't just change it through cabinet. We've got to go back to Parliament and take all that time and money to restore service providers to their rightful place in our society.

I just beg you to change your mind on this because to date you've had ample opportunity to make arguments why you need this rule, why it provides better services, and you failed. We've given you other models that don't require you setting up a monopoly. You heard the Canadian Association of Retired Persons confirm yesterday what we've been saying, and that is that the deal on long-term care was that the government would establish—

**Mr. Malkowski:** You're not listening to Ontario seniors.

**Mr. Jim Wilson:** Well, who do you think retired

persons are, for the most part? They're seniors, for goodness' sake.

That group very clearly confirmed, without discussing the particulars of this bill, long before this bill, what I heard when I went to those public meetings, that seniors wanted one-stop access, one-stop information. That's what we all thought these MSAs were going to be. We didn't think they'd also be the sole deliverers of services. That is just something the NDP put in this bill. It's the most problematic section.

I know other members want the opportunity to speak on the PC amendment, but I'd ask you to support the amendment. If you truly want local flexibility, this amendment gives you that. It allows local areas to decide who will provide the services based on, as some of the submissions have suggested, price and quality, and I think we have to introduce outcome management. We can't just be totally price-driven. We have to talk about the quality of services. There's no plan by this government to do any outcome management or to set outcomes or to set goal posts. They're just worried about political correctness, and at the end of the day the consumers, the senior citizens of this province, are the losers. So I ask members to reconsider their positions and to support this amendment.

1730

**Ms. Gigantes:** I will not be supporting the Conservative amendment—I believe none of my colleagues will—and I want to take some time to lay out the reasons why.

I'd like to begin by reminding members of the opposition of the fiscal framework that has surrounded the development of long-term care since our government came to office in 1990. Since the budget of the 1990-91 fiscal year, the increase in financial support by the province of Ontario for community-based services, not institutional long-term-care services but community-based services, has been over \$300 million.

Members of the opposition know that the three-year budget forecast with which this government is working currently indicates quite clearly that by fiscal year 1997 there will have been a total increase since 1990 of \$432 million in community-based services in the long-term-care field.

When members of the opposition talk about the choices to be made about how we organize reform of long-term care, it's terribly important that they bear those fiscal realities in mind. Everything that will be happening is happening within a fiscal envelope, a support envelope of increases in the hundreds of millions of dollars since 1990. We are not talking about shrinking funding for long-term care on the community-based side; nor, incidentally, on the institutional side, which has also seen increased funding since 1990 of significant measure. We are talking about an expanding envelope. We are talking about devoting increased resources, increased public tax moneys, to community-based services in long-term care.

I will come back to that point as I speak to the issue before us, which is the objection of the opposition to the 80-20 formula which is set out in this legislation.

The 80-20 formula says that 80% of the services pro-

vided through an MSA must be provided by the MSA itself. In other words, the people who will be providing those services will be employees of the MSA, the MSA being a non-profit, community-based board which will be the employer. It will be a board made up of members from that community. It will have the interests of that community in its mandate as it provides long-term-care services, and a significant number of the members of that board will be people who are in receipt of long-term-care services; in other words, those most directly involved, those for whom this legislation is created and for whom the reform is undertaken.

The other 20% the MSA may purchase. It may purchase those services either from a private profit-making corporation or from a non-profit organization, such as many of those we currently see in the field. That's what this debate is all about. The question is asked, why do we set such a rule? To me the answer is obvious, but to speak about why it's obvious to me, I have to ask members of the opposition to reflect upon our health care system as a whole and what makes it different, for example, from that in the United States.

Many of the arguments that we've heard this afternoon, and for days and weeks and months previous, are the same kinds of arguments that we hear on the American scene as Americans balk and private and public interests compete around the issue about whether they should have a health care system like ours. Our health care system is a monopoly. I know that people don't like public monopolies; it's politically incorrect for Conservatives and Liberals. But they have to face the fact that that's what we have. When Tommy Douglas and the CCF in Saskatchewan began slowly, methodically, carefully doing the work to create the benefits that we now enjoy as Canadians in the health system, then we saw the kinds of results that we have now. But as they began that creation, the same kind of arguments were trotted out.

**Mr Jim Wilson:** It's a single-payer system, not a monopoly.

**Ms Gigantes:** We have a single-payer system. It's the public, and the public is a monopoly in terms of being the payor. There are some private services that are available outside that system, but we all benefit as Canadians, and by gum, you ask Canadians if they want to change that system and you know perfectly well what the answer is, because it assures Canadians of a comprehensive and consistent access—and access that they don't have to pay for—to vital health services when they need them, where they need them.

That's precisely what the MSA is going to do on a community basis when it comes to long-term care. The arguments that we've heard in the United States we laugh at now. As Canadians, we feel enormously smug. We forget our history. There was violent, turbulent objection by powerful interests and by people who were being misled, I will say, by powerful interests on the issue of whether we should have public hospital insurance in Canada and public health insurance for health services in Canada.

I want to remind you of our Ontario history. A very decent man who was a Conservative Premier in Ontario,

Premier Robarts, said, in my living memory politically, "Over my dead body" would the Canadian government, which had finally brought itself to see the value of the Saskatchewan advances, implement the kind of system we now have in Ontario. He had to give in because the public in Ontario spoke and said, "We want it."

Those things are facts, and we're facing the same kinds of decisions here. Let's look at our existing system. We've heard from the opposition, "There's no problem with long-term care." That is just not the case. There is a problem with long-term care, there has been and there will be, unless we undertake some very specific reforms. There have been communities in which the most basic of long-term-care services have not been available. We have seen a struggle in the services that have been offered to senior citizens in this province when they've had chronic health needs for years and years and years.

**Mrs Sullivan:** On a point of order, Mr Chair: The member is certainly distorting the point of view that our party has expressed in these hearings with respect to long-term-care reform, and I believe that the information that she's providing now with respect to the position that we've taken is quite incorrect and misleading.

**The Acting Chair:** Thank you.

1740

**Ms Gigantes:** That's not a point of order, Mr Chair, and I don't need to point that out to you.

The struggle that has gone on has been one between, first of all, whether we provide care for older people who have chronic health needs in an institutional setting or whether we build up the community-based living supports that allow them to deal with their chronic health problems in their homes, in their communities, as close to their normal life as possible.

That struggle has gone on for years. As we go through long-term-care reform, what we are saying is that we are going to stop being the society in the modern industrial world which most heavily institutionalizes its senior citizens and we are slowly and carefully going to build up the alternative systems at the community level that will allow people who have chronic health needs not to be placed in institutions but to live in their own homes and to get the kind of services they need there.

There is another kind of struggle that's been going on—again, it's an elemental kind of decision when you look at health services—and that is the question of whether we follow a medical model. Not just whether it's institutional as opposed to community-based, but whether when you provide the community-based services, you put all your focus on the medical model or whether you start to consider that if people have help doing the very basic things in their lives—feeding themselves, having some help with the heavy work around the house, being able to do things that require transportation—if we provide those kinds of supports, we don't need nurses, we don't need high-skilled medical service providers. We don't need doctors. We don't need nurses. We need some well-trained living-support assistance.

There are two basic issues here that we have to think about in this reform that we're following. One is that

we're moving people from a destiny of institutionalization and the second is that we're saying to them, as they're able to stay at home, "It's not necessarily a very rigid program of medical services you need, it may be some mix of medical service, but you may need basically some trained support-to-living service." We all know that. There isn't a member in this Legislature who doesn't know those two items are key to what's before us.

Getting those changes is not easy. There are interests involved in seeing the old models preserved. There are institutional interests, there are hospital and chronic hospital interests, there are medical interests, there are nursing interests, there are organizational interests, both private sector and public sector, and we all know that. Let's say those truths.

When we get to how we reorganize so that we have a model at the community level which can provide what seniors need for their chronic health needs, how do we do that? Do we just say to the existing organizations and institutions, "Well, work it out together"? Some of them are big and powerful and get paid one way. For example, in the past, if an elderly person with a chronic health need was placed in a chronic care hospital there was no cost. You know what that is: That's an incentive for service to be provided in an institution. Because for that individual, for the family that is supporting that individual in many cases, it means it's free.

What is the incentive to have the service at home when in many cases you have to pay for it? That's what the existing system gives us. When it gives us home-based services, and many communities haven't had them, you had to pay for those basic living-support services far too often.

In the community I come from—

**Mrs Sullivan:** This bill specifically requires payment for those services.

**Mr Jim Wilson:** You're legislating those—

**Ms Gigantes:** In the community I come from, Mr Chair—

**Mrs Sullivan:** You better read your own legislation.

**Ms Gigantes:** —and where you come from—

**Mr Jim Wilson:** You're legislating waiting lists here.

**Ms Gigantes:** —most of the budget—

**Mrs Sullivan:** Better read the act.

**The Acting Chair:** Order, please.

*Interjections.*

**The Acting Chair:** Ms Gigantes has the floor.

**Ms Gigantes:** Mr Chair, in the community in which you and I live, most of the services that are provided at the community base, in terms of the amount of money spent, are in the home care program. Most of those services are provided by private enterprise, about 75%. That's where the money's going. That doesn't mean that in our communities—

**Mrs Sullivan:** That's it exactly, the same as non-profit organizations.

*Interjections.*

**Ms Gigantes:** It hurts, Mr Chair, it hurts.

**The Acting Chair:** Order, please.

**Mrs Sullivan:** You're going to put them all out of business, anyhow. You're going to take them all out of business. You don't even know that you're billing charges to people for services they get. You better read your own legislation before you go on a big rant and rave around here.

**The Acting Chair:** Order, please.

**Ms Gigantes:** You should have to stay after school for bad behaviour.

**Mrs Sullivan:** Oh, wow, condescending.

**Ms Gigantes:** May I, Mr Chair?

**The Acting Chair:** Please continue.

**Ms Gigantes:** In our community, Mr Chair, with the kind of allocation of moneys that I've described, which you know to be the case, in the community-based service field, we do not know that this is the best way for those moneys to be spent. That's why you have the proposal in this legislation that there be a non-profit organization of people drawn from the community, including clients of these services, to decide what the priorities within the community are. In fact, should we have more of the supports-to-living programs, the simple things that trained personnel, who don't have to be medical personnel, can provide?

**Mrs Sullivan:** They already do that. What's your point?

**Ms Gigantes:** Will those be the areas in which we should make our largest investment of the community base? I think that there is evidence historically that this is the case. We have seen the weight of service go to institutions in the past. We've certainly seen the weight of service go to medical services in the past. I think that we see clearly the need for reform which places the emphasis on the other side.

We don't say that it shall be this much, it shall be that much. We do say that these kinds of services must be provided through an MSA; the amount of each service will be decided by the MSA. We also make a decision that only 20% of those services in each category can be purchased either from a non-profit organization or from a private profit organization.

What is the reason for that, Mr Chair? The opposition pretends not to understand, but I think they do understand. They see the results and they don't like the results on the institutional side, and they don't like the results on what they call the free market side; at least the Conservatives say that. But why is it a good idea?

**Mrs Sullivan:** That's what everybody wants to know.

**Ms Gigantes:** The question has been asked and I will answer it.

**Mrs Sullivan:** That's what we're all trying to find out.

**Ms Gigantes:** If we're going to have an assessment at the community level of what services are most appropriate to the people who live in that community, and it's going to be done without the kind of private and non-profit interests which have so far determined what kinds of services are provided within communities, then there

has to be an assurance that an MSA can operate in an environment where those interests really cannot exert the kind of pressure we've seen them exert at this Legislature.

What we've seen at this Legislature, and every member of this Legislature has seen it and heard it in his or her home community, is a massive lobbying effort, a huge lobbying effort by people who, in good faith, wish to preserve the status quo. The status quo is not adequate. The status quo is not the vision that we see of change for people who need long-term-care services.

1750

If we allow those interests to run rampant at the community level, then we know what the outcome will be: It will be the status quo, because even here at this Legislature the power of the status quo to demand its continued existence is amazing to witness. It's quite marvellous to witness. If we allow that untrammelled power to be focused at the local level, the result is totally predictable: We won't get change.

That is the reason we have to make some very firm decisions about the power that can be exerted by existing organizations and institutions on the local, non-profit, community-based board which will be on behalf of its community assessing the mix of services that are appropriate within that community.

It's very simple, and it's the kind of very basic choice that has had to be made in the past when we decide whether we allow private insurance companies to continue to provide insurance coverage for basic health insurance. If you do that, as the CCF pointed out many years ago in Saskatchewan, then you can't have a public health system.

As we saw in Ontario when the issue came to that, when the federal government finally said: "We want hospital insurance that is publicly paid. Yes, we're getting the private hospital insurers out of the business," there were whoops and cries. It was the same kind of noise. We've heard it all before.

I'm going to repeat to you one of the lines that I love best from Tommy Douglas's experience. It was the first stage of health reform in Saskatchewan which was in the hospital insurance field, and he was being accused by many powerfully placed opponents of wishing to have the government actually run hospitals and decide everything that happened in the hospitals, and he said, "I want to assure members of the loyal opposition that I have no interest in changing the bedpans in the Estevan hospital."

It always struck me that he had summed up in that phrase the kind of decision that had to be made which was that you take on a political choice for change and you take on a public responsibility for it and you used public resources to do it because you know that's the only way you're going to get basic change, but it doesn't mean that there is bureaucracy involved in that. It does not mean that the government decides what happens in a hospital. Nor does it mean that the government decides in the community of Ottawa-Carleton or in whatever community in Ontario what a multiservice agency will decide about the appropriate mix of services.

What the government has an obligation to do is to ensure that there's a framework in which that non-profit, community-based board can make its decisions without simply being trampled by existing interests who are very well spoken for outside this Legislature and within this Legislature.

If we leave the community-based organizations, the multiservice boards, exposed to this kind of lobbying, we are condemning them to failure. We are condemning reform to failure. Just as if we had left the private insurance companies involved in insuring basic health services, we would have condemned ourselves to the kind of system that the Americans have, where words like "choice" and "freedom" and "bureaucracy" and "democracy," all these catchwords, get thrown around to confuse the real issue. Those issues have been clearly identified to us from the past. To hear members of the opposition talk now, they would have been in opposition to the creation of the public health system about which we are, and we deserve to be, so proud.

This is a very basic part of what we have to do to make sure that in the future we have a system of services available, not just to seniors in a lucky urban centre but throughout Ontario, that can meet their needs, that doesn't overinstitutionalize them, that doesn't over-medicalize their chronic health problems, that meets their needs with the lowest possible technology, that meets their real needs, that assesses those real needs and responds in a real way.

We're proposing to do that within an increasing fiscal envelope, within an increasing allotment of public resources, and we do that because we think it's an enormously important thing to be doing. It's important to the health of this society. We will be in advance of where we are today. Seniors and people with chronic health needs who have disabilities will be served in a way they are not served today. The system will be consistent across this province, it will be comprehensive, and everybody who needs long-term-care services will be able to access them.

That's why we need the 80-20 and that's why I fully support it and I reject the amendment.

**Mrs Sullivan:** Just as I begin my remarks on this section of the bill, and I'm sure we'll have to continue them, I'd just like to read into the record a release that was issued today, November 15. It reads as follows:

"For immediate release.

"Municipalities Continue Opposition to Bill 173.

"Toronto—"Bill 173, the Long-Term Care Act, will not achieve improved access and better coordination of long-term-care services, and we question the government's assertion that the proposed system will cost less. We therefore cannot support the legislation in its current form," said Bill Mickle, president of the Association of Municipalities of Ontario.

"The Association of Municipalities of Ontario is a non-profit organization with membership from approximately 700 of Ontario's 817 municipal governments, representing over 95% of the province's population.

"Mr Mickle, who is also the reeve of the town of

Exeter, was commenting on the association's brief to the standing committee on social development which it presented in September. AMO argued that the reform will not achieve the following objectives: greater community empowerment, decentralized decision-making, integrated local programs and services, accountability, reduced government bureaucracy, or an efficient allocation of limited government resources.

"We question the move to one large bureaucracy, that is called a multiservice agency, to both coordinate and deliver long-term-care services directly. During the past several years of discussions on long-term-care reform, the association has supported the establishment of one agency to coordinate long-term-care services in order to provide "single window" access to services. The government's decision to amalgamate all service providers into one big central agency will only serve to suppress local initiative, voluntarism and private-sector services," said Mr Mickle.

"The association has lobbied and argued against this direction and the stipulation that all other approved agencies must be considered first before a municipality or board of health can be designated as an MSA. Currently, in municipalities across the province, there are well-established boards of health and municipal health departments which currently deliver home care programs, are connected to other municipal services, perform placement

coordination functions, and are accountable to elected councils. Leaving municipalities as a last resort signals that criteria such as selecting the best qualified agency and ensuring local accountability on the spending of government funds are not important.

"We agree with the objectives for reform presented by consumers and other providers: easier access, more services, improved coordination and the continuation of support for services provided by families and volunteers. However, we do not believe that Bill 173 will achieve these important consumer requirements," said President Mickle.

"Other issues which still need to be addressed are the implications for existing staff in municipal health departments who are delivering home care programs and are covered by collective agreements, and the impacts on existing contractual arrangements with private service providers."

Mr Chair, it now being 6 of the clock, I will take up my debate on this particular amendment at the next session.

**The Acting Chair:** Fine. This committee stands adjourned until Monday, November 21, at 3:30 in the afternoon.

*The committee adjourned at 1802.*







## CONTENTS

Tuesday 15 November 1994

**Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,**  
projet de loi 173, M<sup>me</sup> Grier ..... S-2537

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair /Vice-Président:** Eddy, Ron (Brant-Haldimand L)

**\*Acting Chair / Président suppléant:** McGuinty, Dalton (Ottawa South/-Sud L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

\*Gigantes, Evelyn, (Ottawa Centre ND)

Jamison, Norm (Norfolk ND)

\*Martin, Tony (Sault Ste Marie ND)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

Malkowski, Gary (York East/-Est ND) for Mr Rizzo

Sullivan, Barbara (Halton Centre L) for Mr Beer

Wessenger, Paul (Simcoe Centre ND) for Mr Jamison

#### **Also taking part / Autres participants et participantes:**

Wessenger, Paul, parliamentary assistant to Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gottheil, Joanne, legislative counsel



S-79

S-79

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

## Official Report of Debates (Hansard)

Monday 21 November 1994

## Journal des débats (Hansard)

Lundi 21 novembre 1994

Standing committee on  
social development

Comité permanent des  
affaires sociales

Long-Term Care Act, 1994

Loi de 1994 sur les soins  
de longue durée

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

50th anniversary

1944–1994

50<sup>e</sup> anniversaire

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 21 November 1994

Lundi 21 novembre 1994

*The committee met at 1533 in room 151.*

LONG-TERM CARE ACT, 1994

LOI DE 1994

SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

**The Chair (Mr Charles Beer):** We are considering Bill 173, and this afternoon we meet to continue clause-by-clause consideration of the bill.

Before we resume, I would remind all members that by order of the House dated Thursday, 17 November 1994, at 4 o'clock today, the Chair is required to interrupt the proceedings regardless of where we are with the amendments. At that time, there shall be no further amendment or debate. The Chair will "put every question necessary to dispose of all remaining sections of the bill and any amendments thereto. The Chair may allow only one 20-minute waiting period if requested pursuant to standing order 128(a)."

I have directed the clerk to distribute to all members a set of all amendments filed with the clerk of the committee prior to 12 noon today, and I believe you all have that.

That being said, we were, at the close of proceedings when last we met, dealing with a Progressive Conservative motion.

**Mr Jim Wilson (Simcoe West):** Just to clarify, is that subsection 13(1.1) or subsection 13(2)?

**The Chair:** It's 13(1.1).

**Mr Jim Wilson:** And it had been read into the record?

**The Chair:** Yes, it had.

**Mr Jim Wilson:** Again, given that the government has flexed its muscles and imposed its majority and we'll be shut down on debate in just 25 minutes, this motion is an attempt to remove the 80-20 rule which we feel is the most draconian part of this legislation. We've had extensive debate on it, and given the time limitations, I suggest we vote on the PC motion.

**The Chair:** All those in favour of—

**Mr Jim Wilson:** Recorded vote for this.

**The Chair:** All those in favour of Mr Wilson's motion?

Ayes

Jackson, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** All those opposed?

Nays

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** I declare the motion lost. We then move to another Progressive Conservative motion, Mr Wilson.

**Mr Jim Wilson:** I move that clause 13(2) of the bill be struck out. Again, an attempt to remove the 80-20 rule provisions from Bill 173.

**Ms Evelyn Gigantes (Ottawa Centre):** I'm just looking at the specifics, but haven't we just had a motion to that effect?

**The Chair:** Yes. Now, are you working out of the material that the clerk has just distributed?

**Ms Gigantes:** Yes. So perhaps you could remind me.

**The Chair:** Yes. The motion that we are dealing with is an amendment to 13(2) of the bill. We'll just take a moment to doublecheck to make sure you have that. That would have been in the original set of amendments, and we're going to check because with all of the amendments, it should be there. Maybe I could just ask the clerk to have a quick look and see if—

**Ms Gigantes:** What my question is, is whether this particular motion is not redundant considering the nature of the motion we just voted on. According to Mr Wilson, it has the same purpose.

**The Chair:** Mr Wilson, did you wish to comment on that?

**Mr Jim Wilson:** Subsection 13(1.1) was certainly an addition to the bill saying there shall be no limitation in the amounts of purchased service within the approved budget. When that's defeated, it's necessary now to move to a different motion which would strike out the government's original section, and I think it's in order and not redundant.

**The Chair:** Any further discussion on Ms Gigantes's point? One moment.

The motion, Mr Wilson, is redundant and out of order. We then move on to the next amendment, which is a Liberal amendment.

**Mrs Barbara Sullivan (Halton Centre):** I move that subsections 13(2) and (3) of the bill be struck out and the following substituted:

"13(2) Within the approved budget, a multiservice agency shall determine from time to time the optimum mix of community services which it may provide directly and the amount of community services which it may

purchase from other service providers.

"(3) A multiservice agency may purchase a community service from another multiservice agency, a service provider, an individual or a person."

This amendment would give increased responsibility to the MSA for analysing and evaluating the services that are required in their area, and for ensuring the delivery either from within the agency or from without the agency as the agency determines. I'd suggest that we proceed to vote on this amendment.

**Ms Gigantes:** I would have the same question about this motion.

**The Chair:** The motion is out of order.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** It doesn't seem to be redundant in that it's an entirely different idea and that's what we're trying to substitute. I don't understand; is it duplication? This is what everybody's been asking for and we wanted to place it in the bill.

**The Chair:** I appreciate that, but it is still covering what has been dealt with, and that's why it is out of order.

We then move to a government motion.

**Mr Paul Wessenger (Simcoe Centre):** I move that clause 13(2)(a) of the bill be struck out and the following substituted:

"(a) for the purchase of community support services, other than adult day programs, from other service providers, more than 20% of the amount budgeted for community support services other than adult day programs in the agency's approved budget."

This amendment exempts adult day programs from the purchase-of-service limit and ensures that existing day programs which are tied to facilities or other programs can continue.

1540

**Mrs Sullivan:** We like what the government has done as far as it goes. Unfortunately, we don't feel that it's gone far enough because there are other specialized services that are not considered which are also frequently day programs such as those provided for children in treatment centres and specialty services such as those which have been identified by people who've come before the committee, such as individuals requiring specialized respiratory care and other types of care. What the government has done is to say that where programs have been established in facilities, only in adult day care will there be an exemption of the 20% rule. We feel that it is just not adequate to meet the real need that exists.

**Mr Jim Wilson:** Again the government has not gone far enough. There was a whole ream of services that needed to be exempt from the 80-20 rule and I think it's rather hypocritical and unfair of the government to only be exempting adult day programs in this section of the act. I hope government members can live with their consciences with respect to their ruining of the rest of the sector.

**Mr Tony Martin (Sault Ste Marie):** I just want to say that this amendment brought forward reflects very clearly our attempt to, as much as we can without taking

away from the essence of the bill, respond to some of the very legitimate and sincere concern raised as we travelled the province. This issue particularly was raised in a number of locations and it's nice to see it here on the table today by way of amendment and we hope it will go a long way to protect some of the very excellent day programs that are out there being offered by folks in many communities across the province. So I will certainly, as will I'm sure my caucus colleagues, be supporting this amendment.

**Mr Cameron Jackson (Burlington South):** I'm a little concerned that we heard the exact same thing from children's treatment centres in terms of services for disabled children, and although I will support this I want the government members to realize that they're saying yes to adults and they're saying no to disabled children in terms of this additional movement beyond the 20%. That is of serious concern. I thought the bill in and of itself would not contain discriminatory language or differentiation based on a range of disabilities, and clearly this motion implies that. It's nice that the government will pop out one part of it, but they're also saying no to several others.

The other point I want to make is with a question. We don't have the regulations, but is it possible then that the regulations can be written in such a way that for every expenditure beyond the 20 percentile for adult programs will result in an equal and opposite decrease in the external purchasing power for an MSA? I suspect that could be written into the regs. We don't have the regs so it's even possible to reduce even more one other support service to seniors because they're ballooning or going beyond the 20%.

Since we don't have the regs in front of us, unless the government's prepared to give us an absolute assurance that it'll allow the ceiling to be breached but under no circumstances will there be a coterminous adjustment for other programs, since the 80-20 rule is in and of itself a restrictive formula—so when you break it out in one area, are you going to make it up in another? The regs could clearly do that, and I am frightened of that.

**Mr Wessenger:** I think, first of all, the 20-80 rule applies to each service across the board and there is no provision of making up with respect to one area what might be exceeded in another. Anyway, it's not the intention really. The intention here of excluding the adult day programs is the fact that arguments were made that we should be encouraging the integration of facility and community care, and by having this exemption we are encouraging the fact that facilities are providing some of these day programs and ought to be able to continue.

Last, I'd like to indicate that, with respect to children's services, it is very clear that the 20% rule would very easily accommodate any of the purchased services for shelter. Of course, in addition children's treatment centres are funded separately to some extent, and there's that flexibility as well in the program.

**Mr Jackson:** The parliamentary assistant is dreaming in Technicolor. He doesn't know very much about children's disabilities.

**The Chair:** Are there any other comments? We'll

move to the vote on the government motion.

All those in favour? Opposed? Carried.

Mr Wilson, the next motion is yours.

**Mr Jim Wilson:** I withdraw it, Mr Chairman.

**Mr Jackson:** Where is 13(3)(b)?

**The Chair:** Sorry, Mr Wilson, I will give you a further opportunity to withdraw that, but I jumped ahead of myself. There is another government motion which you have by hand.

**Mr Wessinger:** I move that clause 13(3)(b) of the bill be struck out and the following substituted:

"(b) the purchase is necessitated by a short-term absence of an employee of the multiservice agency and the absence is due to the employee's illness or an unplanned event but is not due to a strike or lockout."

The purpose of this amendment is to make clear that an unplanned event would not include a strike or lockout. It was never the intention that it would include such a situation.

**Mrs Sullivan:** We will not be supporting this motion. In fact, we think it's an unconscionable one. What it says is that during any period of labour strife, whether it is a strike or a lockout, people will not receive the care from providers, there will be no exemption to the 20% rule for those individuals who are providing service to people in the community, and as a consequence the person who's at home receiving care, usually who is frail, usually who's elderly, usually who's lonely, usually who's sick, just won't get the care. This is absolutely appalling.

**Mr Jim Wilson:** I'll certainly be voting against this amendment also. It's just cruel, absolutely cruel in the extreme. It means that if there is a strike or lockout, whether it's illegal or otherwise, the people who are supposed to be receiving these necessary services will be simply out of luck. It enables a few unions in this province to deny the frail elderly and the disabled services during the period of a strike or lockout and is absolutely horrid, and I wish the government would rethink their amendment.

**Mr Larry O'Connor (Durham-York):** I certainly will be supporting this, and I think that it's important that we realize that as we go through this process, there have been people who have been in the provision of long-term care today who are in situations now where they do have a collective agreement and they aren't out there trying to undermine the services that they are providing and are providing good services. It's rather strange that my opposition colleagues are painting this as some sort of service when it's being provided by somebody with a collective agreement, that they don't care about individuals any more than any care provider out there today. So I certainly will be supporting this motion.

**Mr Jackson:** In good conscience I can't support this, but I will at least try an amendment because I caution the government. Perhaps I should move the amendment and then speak to the amendment to the amendment.

I move that clause 13(3)(b) of the bill be further amended by adding the word "legal" in front of the word "strike."

My reason for stating that is that it's the history of collective bargaining in this province, as seen in examples of people conducting illegal strikes or illegal lockouts, and this legislation written in this form would indicate that any kind of strike by definition would allow the system to be brought to its knees. Although the government would want to support what they think is the collective bargaining process, I'm sure they don't endorse the fact that, should there be a grievance and the union not be happy with that grievance and then they conduct an immediate walk off the job and leave our seniors in their homes by themselves, then that would be an illegal strike or an unauthorized strike within the meaning of the act and yet that could occur just as a wake-up call for the MSA in terms of getting any of the bargaining demands they want.

What frightens me is that this could become the norm in terms of an approach, and certainly to hear Sid Ryan come forward before this committee with his view of the world, there's a very real risk of that.

I think it's just a mild form of additional protection that the grievance procedure can't be used as a vehicle with this loose wording. I think it should be a legal strike in accordance with the appropriate act or a legal lockout in accordance with a given act, but the concepts of any kind of strike for any reason whatsoever.

Having done that, I also want to ask, when the parliamentary assistant responds, about occupational health and safety issues and refusing services to an individual on that basis as well.

1550

**The Chair:** I will ask the parliamentary assistant to comment, but just for everyone to understand, we are now dealing with the amendment to the amendment.

**Mr Wessinger:** I think it would benefit everyone in the committee to have the advice of legal counsel, Mr Strang, with respect to the whole question of the effect of the Labour Relations Act, because this type of service would undoubtedly be an essential service and there's certain protection built into that act with respect to the effect of a strike and lockout. So I'm wondering if Mr Strang might explain the effect of the Labour Relations Act with respect to the essential services.

**The Chair:** Mr Strang, if you'd be good enough to explain the matter to us and also just to identify yourself for Hansard and for the members of the committee.

**Mr Dave Strang:** Dave Strang with the legal services branch, Management Board Secretariat. I'm afraid I just walked in the room. What is the question you would like me to answer?

**Mr Wessinger:** The question is with respect to how the Labour Relations Act would apply with respect to essential services with respect to this particular situation.

**The Chair:** Perhaps in fairness, I should point out, just so you know where we are, do you have in front of you 13(3)(b)? We're dealing with an amendment that Mr Jackson has moved that would put the word "legal" in front of the word "strike" in the last line. So we are now dealing with the amendment to the amendment.

**Mr Jim Wilson:** Could I just add, while legal counsel

is thinking, I think first we have to clarify whether the basket of services and the services contained in there are deemed essential services under the current act.

**The Chair:** Parliamentary assistant, do you want to comment on that while Mr Strang has an opportunity to look at the—

**Mr Wessenger:** It's certainly my opinion that the type of services—

**Mr Jackson:** Your opinion?

**Mr Wessenger:** We could ask legal counsel. I'd be happy to have them indicate their opinion, but nursing care and home care would definitely be in the category of essential services.

**The Chair:** I'll ask legal counsel, then, if he would comment, and then if there are further questions or comments, we'll continue.

**Mrs Sullivan:** This is incorrect information, Mr Chair. The committee is being misled.

**Mr Wessenger:** I'll ask the member to take that back.

**The Chair:** Mr Strang has the floor.

**Mr Strang:** You're asking questions that are quite divergent. The question of whether or not you want to have the word "legal" here, I don't think necessarily relates at all to whether or not the services are essential. You wanted to know whether just using the term "strike or lockout" would include only legal strikes or lockouts and whether or not they—

**Mr Jim Wilson:** Wildcat strikes.

**Mr Strang:** That would cover wildcats, I guess.

The Labour Relations Act does speak to both legal and illegal strikes, so it may well be prudent, if you don't want to cover illegal strikes, to put the word "legal" in there before "strike or lockout." As a practical matter, obviously if there was an illegal strike, presumably you would go before the labour relations board and get an order putting an end to it fairly quickly, so one would hope that the issue would be academic.

**The Chair:** Is there any question or comment? Miss Sullivan?

**Mrs Sullivan:** I want to pursue the question of essential services. I believe that the parliamentary assistant has misled the committee with the information that he's provided, and I'm asking counsel to provide that information.

**The Chair:** Excuse me, Miss Sullivan. Could I ask you to rephrase that.

**Mrs Sullivan:** I believe that the information which the parliamentary assistant provided to the committee is not correct, and I'm asking counsel to confirm what health services are deemed as essential services in the Labour Relations Act. I will tell you that nurses in hospitals aren't essential services; ambulance workers are not essential services. Where does the parliamentary assistant come up with the idea that home care workers are designated as essential workers under the Labour Relations Act? That information is incorrect.

**Mr Jackson:** He did say it was his opinion, though.

**Mr Strang:** Obviously, there can be some debate as

to what are essential services. That's a fairly new term—we've got it in two places now—but I would think it's fairly clear that any service where the withdrawal of that service is going to imperil the life or health of a citizen would be essential. I've now got a copy of the definition in front of me. No. We're dealing here with the definition under the Labour Relations Act. Let's see—

**Mr Jackson:** Mr Chairman, in the interests of time, would it not be appropriate to stand down this section until such time as we've got a clarification. In fairness to Mr Strang, he just walked into the room. We have two other lawyers, counsel, at this table as we speak. Nobody's jumped in, but let me just suggest that maybe we should stand down the section. I think it's an important question to have answered.

**Mr Strang:** I think the definition of "essential service" under the Labour Relations Act appears in 73.2 of the act. There are some specific services that are enunciated in the section, but subsection (3)—

**The Chair:** This is of the Labour Relations Act?

**Mr Strang:** The Labour Relations Act, yes—indicates that replacement workers can be used where it's necessary to enable the employer to prevent danger to life, health or safety, the destruction or serious deterioration of property or premises or serious environmental damage. Clearly, you'd be dealing with danger to life, health or safety, and I would think that if you were talking about nursing service or care necessary to keep somebody fed, you'd have a fairly easy time arguing that that affected health.

**Ms Gigantes:** There are two issues that are being discussed and mixed together here. The question of whether we want to add the word "legal" strike is the issue associated with the amendment; the question of definition of essential services really does not have to do with the amendment that's before us. Can I suggest, however, that what the opposition is casting before us as an image is some kind of experience that we've never had before in Ontario. We've just never had the people who provide services to old, frail people who have chronic health problems—

*Interjections.*

**The Chair:** Order, order. Let Ms Gigantes finish.

**Ms Gigantes:** —behaving in such a way. What we're discussing here is different from the issue—

**The Chair:** Order, please. We have a point of order. Mr Jackson.

**Mr Jackson:** My point of order, Mr Chairman, is on the impugning of a member through the course of the debate.

**Ms Gigantes:** I didn't impugn anybody.

**Mr Jackson:** Yes, you did. Mr Chairman, it was the parliamentary assistant who raised the issue of essential services. I did not. I raised it on the issue of illegal or legal strikes. I'd like to remind the former Health minister of that point.

1600

**Ms Gigantes:** I'm speaking to that—

**Mr Jackson:** That is my point—

**Ms Gigantes:** —if you would allow me to speak.

**The Chair:** Ms Gigantes, if you would complete your comments.

**Ms Gigantes:** The issue that is before us is the issue of what purchase of service will be allowed to a multi-service agency, and what is suggested by this amendment is that there are certain conditions, the absence of an employee for reasons unrelated to a strike or lockout situation. They have to do with the health of the employee. We're saying the multiservice agency should be allowed to hire additional to 20% within that category of service. That's the issue before us in your amendment.

In our amendment—

*Interjections.*

**The Chair:** Order. Ms Gigantes?

**Ms Gigantes:** The question of whether this is a legal strike or not a legal strike is, as Mr Strang has pointed out, somewhat academic, and to raise the notion of whether it's legal or illegal and associated with the 20% rule is different from the question of replacement workers under the Labour Relations Act. The Labour Relations Act will determine whether replacement workers from some other part of the MSA, for example, might be used to substitute a service. If there was a group that was providing service through the MSA which was in a strike or a lockout—

**The Chair:** Order, please. At this point, it being four of the clock, under the order of the House we must then revert to voting on the various amendments. I would like to just note again that I will call the various items and we will have to vote with no debate.

Members will recall that we carried section 1, so we will begin, once I get my notes and you get all of yours—and we will be following the material that the clerk gave out earlier. We will be starting with 2, because we had already approved 1, I believe, and in 2 we had started—

**Mr Jim Wilson:** May I ask the clerk for a new section 2, please?

**The Chair:** Does anyone else need a new roadmap? We're about ready, then. Okay?

We're going to be starting at subsection 2(1), the government motion. I guess we will do that and then we will go back to do 2. So I would then ask all those in favour of the government motion to subsection 2(1) of the bill. Those in favour? Opposed? Carried.

We then go back to subsection 2(1) of the bill, government motion, the one that is at the beginning of your set of papers. All those in favour of subsection 2(1) of the bill? Opposed? Carried.

Again, government motion, subsection 2(1) of the bill. All in favour? Opposed? Carried.

Subsection 2(1) of the bill. All in favour? Opposed? Carried.

Again, government motion, subsection 2(1) of the bill. All those in favour? Opposed? Carried.

Progressive Conservative motion, subsection 2(1) of the bill—

**Mr Jim Wilson:** Withdraw.

**The Chair:** Government motion, subsection 2(1) of the bill. All in favour? Opposed? Carried.

Shall section 2, as amended, carry? All in favour? Opposed? Carried.

Sections 3, 4 and 5 were carried, so we're going to section 6. Are we all on the same—

**Mr Jim Wilson:** We've got section 6, cover page, but nothing in between. There's nothing there?

**The Chair:** We'll just be voting on section 6 as is. Shall section 6 carry? All in favour? Opposed? Carried.

We're at section 7. A government motion, subsection 7(1) of the bill. Shall the government motion carry? Opposed? Carried.

Shall section 7, as amended, carry? All in favour? Opposed? Carried.

Sections 8, 9 and 10 were previously carried. We have a new section 10.1, a government motion. Shall section 10.1 carry?

**Mr Jim Wilson:** Could I just point out for the record that—

**The Chair:** I'm sorry, Mr Wilson. I am under direction from the House. We can have no discussion or debate.

Shall section 10.1 carry? All in favour? Opposed? Carried.

Section 11. A Liberal motion, clause 11(2)(c).

**Mrs Sullivan:** Mr Chairman, all of our motions with respect to first nations have been withdrawn.

**The Chair:** Okay, that's withdrawn. Thank you.

Government motion, subsections 11(2.2) and (2.3) of the bill. Shall the government motion carry? Opposed? Carried.

Government motion, subsection 11(5) of the bill. Shall the motion carry? Opposed? Carried.

PC motion.

**Mr Jim Wilson:** Withdraw.

**The Chair:** Shall section 11, as amended, carry? All in favour? Opposed? Carried.

New section 11.1, a Liberal motion. Shall section 11.1 carry?

**Mrs Sullivan:** Mr Chairman, this amendment was withdrawn.

**The Chair:** Withdrawn. Thank you.

Section 12 was previously carried, I believe.

Section 13. We'll go through in order. Although we had started, I think it would be simpler just to move through in the order in which you find them in your book. Sorry, just one second. Let me just stop for a moment here and make sure my head is clear. We have already voted on the various motions that are there, up to but not including Mr Jackson's amendment to the government amendment. So the first vote will be on Mr Jackson's amendment to the government motion.

**Mr Jim Wilson:** Recorded vote.

**The Chair:** All those in favour of Mr Jackson's amendment?

**Ayes**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** All those opposed?

**Nays**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** We will then vote on the government motion, clause 13(3)(b).

**Mrs Sullivan:** A recorded vote, please.

**The Chair:** All those in favour?

**Ayes**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** All those opposed?

**Nays**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** The amendment is carried.

1610

We then have Conservative motion, subsection 13(3) of the bill.

**Mr Jim Wilson:** Withdrawn.

**The Chair:** Withdrawn. Shall section 13, as—

**Mr Jim Wilson:** Recorded vote.

**The Chair:** Shall section 13, as amended, carry? All those in favour?

**Ayes**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** Opposed?

**Nays**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** We then move to section 14. The first motion is a Liberal motion, subsection 14(1). All those in favour of the motion? All those opposed? The motion is defeated.

Conservative motion, subsection 14(1) of the bill. All those in favour?

**Ms Gigantes:** It's the same.

**The Chair:** Same. Defeated.

Government motion, subsection 14(1.1). All those in favour? Opposed? Carried.

The next one is a Liberal motion, subsection 14(2). All those in favour? Opposed? Defeated.

Conservative motion, subsection 14(2). All those in favour? Opposed? Defeated.

Liberal motion, section 14. All those in favour? Opposed? Defeated.

Shall section 14, as amended, carry? All in favour? Opposed? Carried.

Government motion for section 14.1 of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

We then have a Conservative motion. Shall the motion carry? All those opposed? Defeated.

**Ms Gigantes:** Can I ask you, Mr Chair, on a point of order: We passed government motion 14(1.1) earlier.

**The Chair:** We did.

**Ms Gigantes:** And as I read it, that really incorporates the Conservative motion.

**Mr Jim Wilson:** The government would be forced into voting for the PC motion, I would think.

**Ms Gigantes:** But the PC motion is out of order, given that we've already passed it.

**The Chair:** It is redundant.

**Ms Gigantes:** Did you vote against it? I bet you did.

**Mr Jim Wilson:** We voted in favour of it.

**The Chair:** The second motion then is redundant.

Conservative motion, section 15 of the bill. All those in favour? Opposed. Defeated.

Another Conservative motion. All in favour? Opposed? Defeated.

Government motion, subsection 15(1) of the bill.

**Mrs Sullivan:** On a point of order, Mr Chair: I request a ruling with respect to the admissibility of this amendment because I believe it to be out of order.

**The Chair:** We'll just take a moment to—

**Mrs Sullivan:** Sorry, Mr Chair, I'm on the wrong section. I thought it was 15.1.

**The Chair:** All right. We'll then proceed with the vote on government motion subsection 15(1). All those in favour? Opposed? Carried.

**Mrs Sullivan:** We're not putting forward an amendment to 15(1).

**The Chair:** The Liberal motion is withdrawn.

The next is a Liberal motion. I'm just going to read that so your copy is like mine: "that subsection 15(2) of the bill be struck out." That's what we're voting on. All those in favour? Opposed? Defeated.

Conservative motion to 15(2) is next. All in favour? Opposed? Defeated.

We then have a Liberal motion to section 15 of the bill. All in favour? Opposed? Defeated. Shall section 15, as amended, carry? All in favour? Opposed? It carries.

We now have a new section, 15.1 to 15.3.

**Mrs Sullivan:** This amendment, on which I request a ruling, is, I believe, out of order.

**The Chair:** Just so I'm clear, on the government motion 15.1 to 15.3, you're asking for a ruling.

**Mrs Sullivan:** Yes.

**The Chair:** The Chair rules that this motion is in order. All those in favour of—

**Mr Jim Wilson:** Recorded vote.

**The Chair:** Recorded vote. All those in favour of the government motion?

**Ayes**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** All those opposed?

**Nays**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** The motion carries. We have next a Conservative motion to sections 15.1 to 15.3 of the bill.

**Mr Jim Wilson:** Recorded vote.

**The Chair:** All those in favour of the Conservative motion?

**Ayes**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** Opposed?

**Nays**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** The motion is defeated.

Section 16: We need to vote on section 16. All those in favour of section 16? All those opposed? Carried.

We move on to section 17. Shall section 17 carry? All those opposed? Section 17 of the bill is defeated.

Shall section 18 of the bill carry? All those in favour? Opposed? Carried.

1620

Shall section 19 of the bill carry? All those in favour? Opposed? Carried.

We come then to section 20 of the bill, government motion 20(2)(b). Shall clause 20(2)(b) of the bill carry? All those in favour? Opposed? Carried.

Government motion to 20(2.1). Shall that subsection carry? All in favour? Opposed? Carried.

Conservative motion to subsections 20(2.1) and (4.1). Shall the Conservative motion carry? All those in favour? Opposed. Defeated.

A Conservative motion to section 20 of the bill. Shall the motion carry? All those in favour? Opposed? Defeated.

A Liberal motion to subsection 20(3) of the bill. Shall the Liberal motion carry? All those in favour? Opposed? Carried.

Government motion to subsection 20(3.1) of the bill. Shall the subsection carry? All in favour? Opposed? Carried.

Government motion to subsection 20(3.2) of the bill. Shall it carry? All in favour? Opposed? Carried.

Subsection 20(4), government motion. Shall the subsection carry? All in favour? Opposed? Carried.

Shall section 20 of the bill, as amended, carry? All in favour? Opposed. Carried.

We then move to section 21. Government motion, subsection 21(1), shall the subsection carry? All in favour? Opposed? Carried.

Liberal motion—

**Mrs Sullivan:** Withdrawn.

**The Chair:** Conservative motion—

**Mr Jim Wilson:** Withdrawn.

**The Chair:** Liberal motion, section 21 of the bill, all

those in favour? Opposed? Defeated.

Conservative motion to section 21, recorded vote, all those in favour?

**Ayes**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** Opposed?

**Nays**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** Defeated.

Shall section 21, as amended, carry? All in favour? Opposed? Carried.

Shall section 22 carry? All in favour? Opposed? Carried.

Section 23, government motion, section 23 of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

What's the next one? I believe the next one is redundant, a Liberal motion, Ms Sullivan?

**Mrs Sullivan:** That's withdrawn.

**The Chair:** Conservative motion, Mr Wilson?

**Mr Jim Wilson:** That's withdrawn.

**The Chair:** Shall section 23, as amended, carry? All in favour? Opposed? Carried.

We then have a new section 23.1, a government motion. All those in favour of section 23.1? Opposed. Carried.

Shall section 24 carry? All in favour? Opposed? Carried.

Shall section 25 carry? All in favour? Opposed? Carried.

Shall section 26 carry? All in favour? Opposed? Carried.

Shall section 27 carry? All in favour? Opposed? Carried.

We have a new section 27.1, a Liberal motion. Shall the Liberal motion carry? All in favour? Opposed? Defeated.

Shall section 28 carry? All in favour? Opposed? Carried.

We then have a government motion, new sections 28.1 to 28.4. Shall the government motion carry? Opposed? Carried.

Section 29, a government motion to section 29 of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

We then have a Liberal motion to subsection 29(1) of the bill. Mrs Sullivan, is this one of the ones that's withdrawn?

**Mrs Sullivan:** That's being withdrawn.

**The Chair:** Government motion, subsections 29(3.1) and (3.2). Shall the government motion carry? All in favour? Opposed? Carried.

Government motion to subsection 29(4) of the bill. Shall the government motion carry? All in favour?

Opposed? Carried.

Government motion to subsections 29(9.1) and (9.2). Shall the government motion carry? All in favour? Opposed? Carried.

Government motion to subsections 29(13), (14) and (15) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Government motion to subsection 29(16). Shall the government motion carry? All in favour? Opposed? Carried.

Government motion to subsection 29(17). Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 29, as amended, carry? All in favour? Opposed? Carried.

Section 30 of the bill. Government motion, clause 30(3)(a). Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 30, as amended, carry? All in favour? Opposed? Carried.

Shall section 31 carry? All in favour? Opposed? Carried.

New section, 31.1: a government motion. Shall the government motion carry? All in favour? Opposed? Carried.

A Liberal motion to section 31.1 is the same, I believe.

**Mrs Sullivan:** No, it isn't. It's different in the time lines.

**The Chair:** Okay, sorry. So the Liberal motion, section 31.1. Shall the Liberal motion carry? All those in favour? Opposed? Defeated.

Section 32 of the bill, a government motion. Shall the government motion carry? All in favour? Opposed? Carried.

A Liberal motion, section 32 of the bill. Shall the Liberal motion carry?

**Mrs Sullivan:** Withdrawn.

**The Chair:** Shall section 32 of the bill, as amended, carry? All in favour? Opposed? Carried.

Section 33, a government motion to subsection 33(1). Shall the government motion carry? All in favour? Opposed? Carried.

A government motion to subsection 33(2). Shall the government motion carry? Approved? Opposed? Carried.

A government motion to subsection 33(3) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 33 of the bill, as amended, carry? All in favour? Opposed? Carried.

1630

Section 34, government motion. Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 34 of the bill, as amended, carry? All in favour? Opposed? Carried.

Section 35, government motion, subsection 35(1). Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 35 of the bill, as amended, carry? All in favour? Opposed? Carried.

We then have a new section 35.1. Government motion, section 35.1 of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 36 of the bill carry? All in favour? Opposed? Carried.

Shall section 37 of the bill carry? All in favour? Opposed? Carried.

Shall section 38 of the bill carry? All in favour? Opposed? Carried.

Section 39, government motion, subsection 39(2) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Government motion, subsection 39(3). Shall the government motion carry? All in favour? Opposed? Carried.

Government motion, subsection 39(4). Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 39, as amended, carry? All in favour? Opposed? Carried.

Shall section 40 of the bill carry? All in favour? Opposed? Carried.

Section 41, a Liberal motion to clause 41(c). Shall the Liberal motion carry? All in favour? Opposed? Defeated.

Conservative motion to clause 41(v) of the bill. Shall the Conservative motion carry? All in favour? Opposed? Defeated.

Shall section 41 carry? All in favour? Opposed? Carried.

Shall section 42 carry? All in favour? Opposed? Carried.

Section 43, Liberal motion, clause 43(d). Shall the Liberal motion carry? All those in favour? Opposed? Defeated.

Government motion, section 43 of the bill. Shall section 43 of the bill carry? All in favour? Opposed? Carried.

Shall section 43, as amended, carry? All those in favour? Opposed? Carried.

Section 44. We have a Conservative motion to subclause 44(1)(c)(vii). Shall the Conservative motion carry? All in favour? Opposed? Defeated.

Government motion to subparagraph 44(2)(1)(ii). Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 44, as amended, carry? All in favour? Opposed? Carried.

Shall section 45 of the bill carry? All in favour? Opposed? Carried.

Shall section 46 of the bill carry? All in favour? Opposed? Carried.

Shall section 47 of the bill carry? All in favour? Opposed? Carried.

Shall section 48 of the bill carry? All in favour? Opposed? Carried.

Shall section 49 of the bill carry? All in favour? Opposed? Carried.

Section 50, Liberal motion, subsection 50(1).

**Mrs Sullivan:** Withdrawn.

**The Chair:** A second Liberal amendment, section 50. All those—

**Mrs Sullivan:** Withdrawn.

**The Chair:** Shall section 50 of the bill carry? All in favour? Opposed? Carried.

Shall section 51 of the bill carry? All in favour? Opposed? Carried.

We then have a new section 51.1, government motion to section 51.1 of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Section 52, government motion, subsection 52(2). Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 52, as amended, carry? All in favour? Opposed? Carried.

Shall 53 carry? All in favour? Opposed? Carried.

New section 53.1, government motion. Shall the government motion carry? All in favour? Opposed? Carried.

New section 53.2, government motion. Shall the government motion carry? All in favour? Opposed? Carried.

Section 54, government motion to clause 54(1)(b). Shall the government motion carry? All in favour? Opposed? Carried.

Government motion, subsection 54(5) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 54 of the bill, as amended, carry? All in favour? Opposed? Carried.

Shall section 55 of the bill carry? All in favour? Opposed? Carried.

Section 56, government motion, paragraph 1 of subsection 56(1) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Government motion to paragraph 9.1 of subsection 56(1) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Government motion, paragraph 11 of subsection 56(1) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

A Liberal motion, paragraph 11 of subsection 56(1). Shall the Liberal motion carry? All in favour? Opposed? Defeated.

Conservative motion to subsection 56(1) of the bill. Shall the Conservative—

**Mr Jim Wilson:** Withdrawn.

**The Chair:** Government motion, paragraph 16 of subsection 56(1) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Government motion, paragraph 18 of subsection 56(1) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Government motion to paragraph 22.1 of subsection 56(1) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Government motion to paragraph 23 of subsection 56(1) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Government motion, paragraph 40.1 of subsection 56(1) of the bill. Shall the government motion carry? All in favour? Opposed? Carried.

Shall section 56, as amended, carry? All in favour? Opposed? Carried.

Shall section 57 carry? All in favour? Opposed? Carried.

We have a new section 57.1.

**Ms Gigantes:** We've got duplicates in our pile here. Just a sec.

**The Chair:** Okay, just one second. I just have one—

**Ms Gigantes:** You're up at 57, are you?

**The Chair:** Section 57.1.

**Ms Gigantes:** We have duplicates starting at 50 at that stage.

**The Chair:** Let's just pause for one second here. Duplicates of 50—

**Ms Gigantes:** From 53 to 57.

**The Chair:** Okay, which we have dealt with; right?

**Mr Wessenger:** You've dealt with.

**The Chair:** Okay. If you could remove those. We are at new section 57.1. Are we all singing from the same hymn book? Okay, new section 57.1, Conservative motion. All those in—

**Mr Jim Wilson:** Recorded vote.

**The Chair:** All those in favour of the Conservative motion?

**Ayes**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** All those opposed?

**Nays**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** It is defeated.

We then move to section 58.

**1640**

**Mrs Sullivan:** I have questions with respect to the next series of government amendments to section 58 and I can name them for you, if you'd like, or do you want me to just do them one by one? This government motion regarding subsection 58(0.1) is one on which I request a ruling.

**The Chair:** Just one moment.

With respect to this subsection, and just for the information of members of the committee, you have all received a copy of the letter from Miss Sullivan regarding a number of motions, so as we go through those I will indicate whether they are in order or out of order.

**Mr O'Connor:** Mr Chair, if I might.

**The Chair:** A point of order?

**Mr O'Connor:** Just on that letter, there was a letter circulated by myself at the beginning of the committee hearings—

**The Chair:** Yes. I appreciate that.

**Mr O'Connor:** —and in your consideration, keep that in mind.

**The Chair:** I thank you. I should note that we have two letters: one from Miss Sullivan and from Mr O'Connor. I have been able to consult in terms of both of those and will be making a ruling on the motions as we go through.

We are then at subsection 58(0.1) of the bill, a government motion. The Chair rules it out of order.

Subsection 58(1.0.1) of the bill is out of order.

We are dealing with subsection 58(1.0.2). It is out of order.

Subsection 58(1.0.3) is out of order.

Subsection 58(1.1) of the bill is out of order.

Subsection 58(1.2) of the bill is out of order.

Government motion, subsection 58(1.3), is out of order.

Government motion, 58(1.4) of the bill, is out of order.

Government motion, subsection 58(1.5), is out of order.

Government motion, subsection 58(1.6), is out of order.

Government motion 58(1.7) is out of order.

Government motion 58(1.8) is out of order.

Government motion, subsection 58(1.9), is out of order.

Government motion, subsection 58(3.1) of the bill, is out of order.

Government motion, subsection 58(6), is out of order.

Government motion 58(7) is out of order.

Shall section 58 of the bill carry? All in favour? Opposed? Carried.

Shall section 59 carry? All those in favour?

**Mr Jim Wilson:** Recorded vote.

**The Chair:** All in favour?

**Ayes**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** All opposed?

**Nays**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** The section carries.

Shall section 60 of the bill carry? All in favour? Opposed? Carried.

**Mrs Sullivan:** On a point of order: Mr Chairman, once again I respectfully request your ruling with respect to the admissibility of government amendments in section 61.

**The Chair:** Okay. Thank you. That is with respect to,

first of all, government motion, subsection 61(0.1). I rule that that is out of order.

Government motion, subsection 61(1.1), out of order.

Government motion to subsection 61(3.0.1) is out of order.

The government motion to subsection 61(3.0.2) is out of order.

The government motion to subsection 61(3.1) is out of order.

Government motion to subsection 61(3.2) is out of order.

The government motion to subsection 61(3.3) is out of order.

The government motion to subsection 61(3.4) is out of order.

Government motion, subsection 61(3.5), is out of order.

Government motion, subsection 61(3.6), is out of order.

Government motion, subsection 61(3.7), is out of order.

Government motion, 61(3.8), is out of order.

Government motion, subsection 61(3.9), is out of order.

Government motion, 61(3.10), is out of order.

Government motion, subsection 61(5), is out of order.

Government motion, subsection 61(6), is out of order.

Government motion, subsection 61(7), is out of order.

Shall section 61 of the bill carry? All in favour? Opposed? Carried.

**1650**

We then come to government motion, subsection 62(1) of the bill. All those in favour? Opposed? Carried.

Subsection 62(1) of the bill, government motion. All those in favour? Opposed? Carried.

Government motion to subsection 62(1). All those in favour? Opposed? Carried.

Government motion, subsection 62(1) of the bill. All those in favour? Opposed? Carried.

Another government motion—

**Mrs Sullivan:** Mr Chairman, could you clarify which reference we are now at since there are several to subsection 62(1)?

**The Chair:** Okay. Sorry. Do you want to know which one we're at right now?

**Mr Jim Wilson:** Yes. There are three 62(1)s.

**The Chair:** Okay. We're at subsection 8.1(6). Am I right? Okay. And we're going to vote on that. We just dealt with 8.1(5). We are now dealing with 8.1(6). Government motion. All those in favour? Opposed? Carried.

Government motion, subsection 62(1). Those in favour? Opposed? Carried.

Government motion, subsection 62(2). All those in favour? Opposed? Carried.

Government motion, subsection 62(3). All those in

favour? Opposed? Carried.

Ms Sullivan, the next one I would assume is withdrawn?

**Mrs Sullivan:** Yes.

**Mr Jim Wilson:** Really?

**Mrs Sullivan:** Oh, no. I think—just give me a second. Perhaps the government counsel will just look at this too because I think that they may have left it out.

**The Chair:** I'm sorry. We cannot debate any of these. I'll have to call the motion or ask you to withdraw it.

**Mrs Sullivan:** Well then, let's vote on it because I think that the government may want to—

**The Chair:** Shall the Liberal motion, subsection 62(5), carry? All those in favour? Opposed? Defeated.

A further Liberal motion, clause 62(5)(a). All those in favour? Opposed? Defeated.

A further Liberal motion—

**Mrs Sullivan:** Withdrawn.

**The Chair:** Shall section 62, as amended, carry? All those in favour? Opposed? Carried.

We then have a new section 62.1. With respect to this government motion 62.1, it is out of order. I'm sorry. I have to make—

**Mr Jim Wilson:** I think your decision should have been exercised earlier.

**The Chair:** We then move to section 63.

**Mrs Sullivan:** On a point of order, Mr Chair: Once again, I have questions with respect to a number of these amendments.

**The Chair:** Okay. The first amendment, government motion, subsection 63(0.0.1), is out of order.

Government motion, subsection 63(0.0.2), is out of order.

Government motion, subsection 63(0.0.3), is out of order.

Government motion, subsection 63(0.1), out of order.

Government motion, subsection 63(0.2), out of order.

Government motion, subsection 63(0.3), out of order.

Government motion, subsection 63(0.4), out of order.

Government motion, subsection 63(0.5), out of order.

Government motion, subsection 63(0.6), out of order.

Government motion, subsection 63(0.7), out of order.

Government motion, subsection 63(0.8), out of order.

Government motion, subsection 63(0.9), out of order.

Government motion, subsection 63(0.10), out of order.

Government motion, subsection 63(3), out of order.

Government motion, subsection 63(4), out of order.

Government motion, subsection 63(5), out of order.

Shall section 63 carry? All in favour? Opposed? Carried.

New section 63.1: This government motion is out of order.

Government motion, section 64 of the bill, is in order. All those in favour? All those opposed?

**Mr Wessenger:** We'll withdraw it.

**The Chair:** Okay. Government motion is withdrawn.

Shall section 64 carry? Carried.

Shall section 65 carry? All those in favour? Opposed? Carried.

Shall the long title of the bill carry? Carried.

Shall Bill 173, as amended, carry? All in favour?

**Mr Jim Wilson:** Recorded vote.

**The Chair:** All in favour?

**Ayes**

Carter, Gigantes, Malkowski, Martin, O'Connor, Wessenger.

**The Chair:** Opposed?

**Nays**

McGuinty, O'Neill (Ottawa-Rideau), Sullivan, Wilson (Simcoe West).

**The Chair:** Shall Bill 173, as amended, be reported to the House? All in favour? Opposed? Carried.

If I might, before adjourning, just note two things: One, I want to thank all members of the staff; the clerk, Hansard, translation, legislative counsel. This has been a very long series of meetings, and also thanks to ministry staff who have been with us during these hearings. I want to thank all of those people for their work.

I would like to ask members of the subcommittee if we could have a meeting tomorrow following routine proceedings to discuss our future workplan.

Unless there are any further matters arising before the committee—seeing none—the standing committee stands adjourned.

*The committee adjourned at 1702.*





## CONTENTS

Monday 21 November 1994

**Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,**  
projet de loi 173, *M<sup>me</sup> Grier* ..... S-2555

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York-Mackenzie L)
- \***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- \*Carter, Jenny (Peterborough ND)  
Cunningham, Dianne (London North/-Nord PC)
- \*Gigantes, Evelyn, (Ottawa Centre ND)  
Jamison, Norm (Norfolk ND)
- \*Martin, Tony (Sault Ste Marie ND)
- \*McGuinty, Dalton (Ottawa South/-Sud L)
- \*O'Connor, Larry (Durham-York ND)
- \*O'Neill, Yvonne (Ottawa-Rideau L)  
Rizzo, Tony (Oakwood ND)
- \*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham  
Malkowski, Gary (York East/-Est ND) for Mr Jamison  
Sullivan, Barbara (Halton Centre L) for Mr Eddy  
Wessenger, Paul (Simcoe Centre ND) for Mr Rizzo

#### **Also taking part / Autres participants et participantes:**

Strang, Dave, legal counsel, Management Board Secretariat  
Wessenger, Paul, parliamentary assistant to Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gottheil, Joanne, legislative counsel



S-80

S-80

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 28 November 1994

# Journal des débats (Hansard)

Lundi 28 novembre 1994

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

**Adoption Disclosure Statute Law  
Amendment Act, 1994**

**Loi de 1994 modifiant des lois  
en ce qui concerne la divulgation  
de renseignements sur les adoptions**

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

**1944–1994**

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 28 November 1994

Lundi 28 novembre 1994

*The committee met at 1535 in room 151.*ADOPTION DISCLOSURE STATUTE LAW  
AMENDMENT ACT, 1994LOI DE 1994 MODIFIANT DES LOIS  
EN CE QUI CONCERNE LA DIVULGATION  
DE RENSEIGNEMENTS SUR LES ADOPTIONS

Consideration of Bill 158, An Act to amend the Vital Statistics Act and the Child and Family Services Act in respect of Adoption Disclosure / Projet de loi 158, Loi modifiant la Loi sur les statistiques de l'état civil et la Loi sur les services à l'enfance et à la famille en ce qui concerne la divulgation de renseignements sur les adoptions.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen. The standing committee on social development is in session, and we are today beginning our review of Bill 158, An Act to amend the Vital Statistics Act and the Child and Family Services Act in respect of Adoption Disclosure.

**Mr Martin,** would you like to make some opening comments? As committee members understand, today we are going to be having a technical briefing. I know you have arranged for officials from the two ministries involved to assist us in that, but if you would like to make some opening comments, please do so.

**Mr Tony Martin (Sault Ste Marie):** Yes, Mr Chair, I want to thank you for this opportunity to—

**The Chair:** We'll provide water and cough syrup as you go along.

**Mr Martin:** Yes, I beg your indulgence. I'm in the middle of a flu-type condition. Everybody's moving now. Had it not been for the fact that this is a private member's bill that I am sponsoring that I need to be here for today, I would be still in Sault Ste Marie, with a very valid excuse in that everybody is snowed in up there and only the crazies got out. So myself and Bud Wildman and a few other hardy folks are on our way.

I wanted to thank you, Chair, for the opportunity to have this piece of business before your committee, the standing committee on social development, and to thank the members of the opposition who supported it at second reading to get it to this point.

Also, the tremendous support and effort from the ministries concerned, the Ministry of Consumer and Commercial Relations and the minister, and particularly the Minister of Community and Social Services, Mr Tony Silipo, who has been very anxious to get this bill moved forward and has worked with me in a very proactive, constructive, positive way to get us where we are today.

This leads me to be quite optimistic, given a good going-over of it at this level, that we will in fact be successful in getting it through the House so that we might, in this day, change in a very significant way, for a very important group of people out there in our province, their ability to access information that is vital to their growing and participating fully in the communities in which they live.

I am not going to speak at length about the rationale and the reasons behind bringing this bill forward; I did that. As I look over my notes and Hansard from Thursday, May 12, 1994, when we brought this bill forward in the Legislature, I see that I covered just about everything and anything that was possible to cover by way of a history of the current legislation, what's happening in other jurisdictions and some of the philosophic underpinnings of why we've done things the way that we have in the past and why it's so very important that we now change and do things differently as we move, indeed, at this very important time in our history towards the end of a century and towards the beginning of a new millennium.

We've seen a lot of change in our society and in our world over the last few short years which speaks of freedom and dignity and empowerment of people, and certainly in my mind this is just one small step in that whole process of giving people what they need to become all that they have the potential to become.

I am thankful today to have with us staff to speak in perhaps more technical language and detail re the bill itself and how each ministry will have to make some changes in order to accommodate some of what we're asking.

I did at the last meeting of the committee suggest that we would have amendments for the committee. I apologize that we weren't able to get them out to you as quickly as I had hoped we might, but we had a bit of a technical glitch in that the legal counsel dealing with this bill up to now, Margaret MacKinnon, who had done an excellent job, retired last week and turned this piece of work over to Cornelia Schuh, who is diligently working as we speak to put the final touches to the package that will be brought forward by way of amendment to this bill. I'm hoping that we'll have it here this afternoon before we finish so that we can distribute it and people can have a look at it, and we can—

**Ms Evelyn Gigantes (Ottawa Centre):** We've received it.

**Mr Martin:** Okay. You may have received it. I wasn't aware of that. If you have, that's great.

**Ms Gigantes:** The amendments.

**The Chair:** If I may, we did receive those today—

**Mr Martin:** Okay. That's super. It works even better than I had thought.

**The Chair:** —while the snow was blowing.

**Mr Martin:** It was while the snow was blowing, yes. That's right. We often think when we go home from this place that everybody stops working, but obviously they don't. It's good. So the amendments are out there and you'll have a look at them.

You will notice in looking at them that they are of a technical nature. They do not in any way interfere at all with the intention of the bill. The amendments are done in order to streamline the process and speak to what each ministry will be expected to do under the new regime.

Basically, if we were to put a simple philosophic or system spin to it, the Ministry of Community and Social Services is going to do the people piece of this, and the Ministry of Consumer and Commercial Relations will deal with and handle the processing of information.

The bill in front of us today amends the Vital Statistics Act to give adult adopted persons access to all the information contained in their original statement of birth without requiring anyone else's consent. The bill also establishes a no-contact register to be administered by the registrar general.

A birth parent who does not wish to be contacted by an adopted person who obtains the birth parent's name from the statement of birth may make that wish known by having his or her name entered in the register. The fact that the birth parent does not wish to be contacted will be communicated to the adopted person when the statement of birth is issued. A person who willfully violates the birth parent's wishes is liable to a fine of up to \$5,000.

The bill also amends the Child and Family Services Act to provide that counselling for adopted persons, birth parents and others who may be affected by the disclosure of information about the adoption must be made available, but is no longer mandatory.

In order to allow birth parents sufficient time to register a no-contact registration, adopted persons will not have access to the information contained in their original statement of birth until one year after the establishment of the no-contact register.

There's just one last point I'd like to make before I pass it on to members of the opposition parties to comment and then to open it up to a technical briefing from ministry staff, and it's this: Certainly as I've spoken to people about this piece of legislation, the only area of concern that seems to come up, and I don't think it's really that significant but I just wanted to mention it, was how this bill and why this bill has come forward, and the process that it is going through. It's coming by way of a private member's bill as opposed to coming directly out of a ministry as part of the government's agenda.

For me, that's not what's important here. What's important here is that this bill is before the Legislature and that it is driven primarily and in any meaningful and significant way by those who are affected directly by the

legislation that covers this area of activity. It is they that we serve in bringing this forward and doing all we can to have it hopefully move expeditiously through this process, make its way back to the House, be passed at third reading and ultimately get royal assent.

So we will in the next few days hear more eloquently than I could ever pretend to present why this bill is so very important to the province and to the folks out there who are affected by it. They will come before us for the next three days, tomorrow and next Monday and Tuesday, to share with us from their experience why this is important, and I, as I'm sure do you, look forward to hearing their story.

**The Chair:** Just before asking Ms O'Neill and Mr Jackson if they would like to make a few brief opening comments and then going to staff from the two ministries, I neglected one thing at the beginning. Just to make this all legal, we need to have the draft report of the subcommittee approved. I'm sure, Mr McGuinty, you would like to so move.

**Mr Dalton McGuinty (Ottawa South):** I certainly would, Mr Chair.

**The Chair:** All in favour? Agreed. Thank you. We are now official and we can proceed.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Bill 158 has finally come to the committee and I presume then it is going to be part of the government's agenda. I presume that it's also going to be passed before the end of this session, because we don't know whether we will be coming back into the Legislature or not. Those are all things I can only trust, because I'm a member of the opposition.

I feel quite strongly that Bill 158 is but a beginning. Indeed, some of the things Mr Arnott passed on to us today indicated that. I also feel that Bill 158 has much in the way of complexity attached to it. It is going to be a very difficult bill to get into gear. I hope that all of the provisions that have been made—and no doubt, I think, the presenters will bring more problems, from the time Bill 158 was presented, to the amendments and then to the explanation of each of the amendments. It is a very complex situation.

I would be less than accurate if I didn't say that I still have some concerns about Bill 158. I certainly will be supporting it both here and in the House, but I have still some reservations. I think individuals, however, with the bill, will have a new level of empowerment in some cases, and they have been waiting a long time. The waiting lists will be shortened and I think that's good. I do feel, however, that those waiting lists will likely be shortened at the cost of individuals; at least at the financial cost of individuals.

I think that the birth parents still have many rights that are not attended to here and I think that will have to be clarified as time goes on, and it won't be part of Bill 158. But at least we have adoption on this government's agenda, as we were promised for a very long time before this government ever came to power. So let's hope that we can work our way through this, that by next week we will have clause-by-clause and that it will be completed

before the House rises next Thursday. That's my hope.

**Mr Cameron Jackson (Burlington South):** I very much welcome the opportunity to participate in this piece of very important legislation. I feel it is long overdue, as has been indicated. I don't wish to suggest that the chances for success of this bill are limited, but the question was raised by Mr Martin about why a private member's bill route was chosen. Both Ms O'Neill and I have attended meetings directly with the minister, and again in estimates as recently as a month and a half ago, where the minister himself indicated this was not a priority for his ministry or his government.

1550

So although I do not in any way question the motives or the good intentions of Mr Martin, I have still several lingering concerns about the level of commitment. I had hoped that in the opening statement Mr Martin may have indicated with a higher degree of certainty that he has talked to his House leader and that this is a piece of legislation which has some priority for the government.

I rose in the Legislature last week to question the government on why, during Adoption Awareness Month, November, as we close that month out, the Premier and the two ministers involved chose not to make an official statement in the House. This 11th-hour responsibility fell to Mr Martin, who has expressed his interest in this subject but specifically did not make any statements about Bill 158, about the government's commitment. I can't think of a better opportunity than when one acknowledges the importance of adoption and adoption rights in the province of Ontario, so I have expressed both publicly and to Mr Martin that I had hoped—

**The Chair:** Excuse me, Mr Jackson. A point of order?

**Mr Martin:** I guess it's not a point of order. Mr Jackson, I did consider in my statement making some note of Bill 158, but I was told by those I rely on for their advice that that's not the purpose of members' statements, to lobby for support or make mention of one's private members' bills. So I chose at that point not to do that. I just thought it would be important to tell you that.

**Mrs O'Neill:** Bad advice.

**Mr Jackson:** I suspect that is a particular point of naïveté that shouldn't exist in someone who's been here for four and a half years, but if that is what you choose to spin, that is your business. I could give you an arm's length of statements by both government and private backbenchers that contain that. However, you might be forearmed with additional advice from this individual or others, especially if they have anything to do with the House leader's office.

Anyway, I was suggesting that perhaps the government might at the outset clarify a very important question with respect to whether this bill has likelihood to get to the floor of the Legislature for third reading. My colleague Ms O'Neill has made reference to the fact that it is the government's stated intention for this Parliament to prorogue on December 8. The reason I raise that question is particularly because if there is absolutely no hope of

that ever getting on the table for a vote, then we may be rushing unnecessarily the final amendments to this bill.

We don't want to put the adoption community into a position where they are being told, "My God, in the interests of time, you've got two days," which really amounts to less than two hours and a bit on each of those days, "to participate in some public input because we have to make this magical deadline," and then find that this magical deadline really doesn't exist.

I think that is a legitimate question in committee, Mr Chairman, and would seek your guidance and clarification, because we will hear people who will come before this committee over the course of the next three meeting days, many of whom have not seen the amendments which the government has prepared, which in and of itself is rather extraordinary. That's fine that they chose to do that, but I'm hopeful that they would have shared those amendments with those groups that are affected that will be coming forward.

But I will be rather dismayed to learn that the government has proceeded with amendments on the eve of public hearings, all with the notion that we must speed the process up really quickly in order to get it on the floor of the Legislature, only to find out that these groups were (a) neither consulted nor (b) would have an opportunity to respond to the amendments before the item is tabled. So I will be asking the Chair for clarification on that point.

Mr Martin did indicate that in fact this bill is driven by them. He was referring to the adoption community, "whom it serves" was his direct quote, and so I would hope that he could clarify that those groups have in fact had an opportunity to have an input in those amendments prior to the public hearing process.

He said, "Hopefully, we'll move quickly and pass third reading sometime," and that word "sometime" doesn't give me the kind of comfort nor do I suspect it gives the adoption community the kind of comfort it's been looking for. They've expressed incredible patience on the part of their agenda with those of us in public life in the last decade, and I think if this is to be done in a timely fashion, then it should in fact get to the floor for third reading in a timely fashion.

I can only say that both my colleague Mr Wilson and I are anxious to participate in this process. I, unfortunately, will have a replacement for tomorrow and will revisit the committee activities for the following week. If I could, Mr Chairman, seek a clarification on those two points that I raised, I think that's rather essential because that will guide the committee in terms of its time.

**The Chair:** If I might at the outset just indicate that, in terms of the amendments, in fact the clerk faxed or mailed them on Friday to those individuals and groups who had been in contact with the committee. So to the extent that we were able to get those out, we have done so as quickly as possible.

**Mr Jackson:** Mr Chairman, my specific question was, if the government had consulted I was aware that the clerk immediately—in fact, some of the groups received them before we as members of the committee did. I'm

not offended by that. I'm trying to determine if the government acted unilaterally or if the government can indicate which individuals it consulted with these amendments. I haven't even physically read the amendments at this point because they only arrived to my office today.

**The Chair:** Yes. I appreciate that, and I just simply for the broader record wanted to indicate what had happened with those. With respect to whom the government and/or Mr Martin may have consulted, and the likelihood of whether this will be dealt with in the House before we rise, I would assume that as we go forward Mr Martin will comment to the extent that he has anything to add to that. I think we have to go forward with our schedule, and if Mr Martin has anything further he can add in answer to your questions, I'd certainly give him the time to do that, but that is up to him.

**Mr Martin:** Just a couple of things: One, the amendments are very much of a technical nature and affect simply the delivery of this whole new set of circumstances by the government so that it is as effective and efficient as possible. We didn't feel it was necessary to go out and do a full consultation with the folks. What we want to do with this is to deliver a package that takes away some of the frustration that is there now for folks, and really, as the folks from the ministries will attest when they speak, they are very much of a technical nature.

The second question you asked: Is passage of this, I guess, guaranteed? I would think that's a bit naïve a question in this place, don't you think?

There's a process that we all work through here at Queen's Park, and in over four and a half years I've certainly learned that we go through one step at a time. If we work hard at it and do our homework—and certainly I've worked hard at this piece, and the fact that we're here today around the table and all of us supporting this I think is probably testimony to that. We probably wouldn't have gotten this far, as you know, if there wasn't some indication from the folks who are responsible—House leaders, the various ministries—of at least a degree of support to give me the comfort and to give us the permission to be here and to be looking at this piece of legislation today.

I can't guarantee passage of this through either this committee or the House, because I don't think any of us can. However, the fact that we're here, I think, is a good sign and that we're not having anybody come forward, at least that I'm aware of, who has some very major and strong objections to this thing I think is an indication that we should expect we'll probably be successful in this.

1600

**Mrs O'Neill:** Mr Chairman, that whole statement just makes me very nervous. I really do not see how we can ask people to come here in good faith from long distances—some of the people are coming from my riding—to this committee in the next two weeks and not know that this is going to be on the House agenda either Wednesday or Thursday of next week. I hope that you as Chair will take this and ask if this is on the agenda of this session of Parliament. Really, if we can't have that guarantee, this is a farce, and this would be a terrible

subject to have in that position.

We have asked for these hearings all through last summer—never happened—even earlier than that, and we couldn't get this on the agenda of this committee. Now even the government members are not able to tell us whether we're going to deal with this before Christmas. I don't know, and neither does anyone sitting here know, whether we'll be back in this Legislature again. And to be told that nobody can guarantee anything when this government has a majority—is it a free vote? I think the government members better say that as well if that's going to be the case.

I cannot see the people who have spent years and years on this subject coming forward not knowing what's going to happen to this bill. I hope you will be able to write and ask the government House leader whether this matter is on our agenda in the Legislative Assembly for third reading next week. He likely will know that as early as this Thursday.

**The Chair:** The Chair, as always, is in the hands of the committee and I can speak to anyone about anything if the committee so directs. I think we have probably expressed the views on that and we should at this point—

**Mr Jackson:** Mr Chairman, there is a matter that deals more with my own personal privilege than it does—but still it impacts on this. The other piece of unattended business before this committee is my private member's bill regarding the proceeds of crime. The Bernardo murder trial is currently before the courts and the Ontario Law Reform Commission is recommending to the Attorney General that there be a proceeds-of-crime form of legislation for Ontario. That could have been, and perhaps should have been, on the agenda, because my private member's bill, I believe, preceded Mr Martin's.

I was led to believe that the government was going to take this legislation and move it forward. We have, by the government's own decision—

**Ms Gigantes:** Stop talking. Let's do it.

**Mr Jackson:** Well, Ms Gigantes interrupts and suggests that maybe we should get on with it and stop talking.

I did indicate that this flows from a matter of privilege because, without getting into the details of the Bernardo case, there's millions of dollars of profiteering that's potential here and I was led to believe that, in the best interests of the adoption community, we were going to have some degree of success proceeding with this legislation. Having bumped profiting-from-crime legislation, which was on this committee's agenda, in favour of adoption, which I accept, now I'm led to believe that there are no guarantees in a half-sneer on the part of the proposer of the bill. I am rather distressed and, frankly, quite angry. I indicated this is a matter of privilege.

**Mr Martin:** Mr Chair—

**The Chair:** Would you complete your point and then we can discuss that.

**Mr Jackson:** Well, I cast this—

**Ms Gigantes:** You don't know human nature when you run into it—

**Mr Jackson:** Ms Gigantes has become an expert in all matters before this committee. I simply wish to indicate that if there is no or limited chance of this bill coming before the House, there are hundreds of individuals who, I am sure, if given proper notice in publication, would like to analyse and contribute to the reconstruction of this bill. My point was that the shortness of the time frame given to this committee is a function of the government's desire to be out of here by December 8, and both Ms O'Neill and I have indicated that's a very short amount of time to do justice to an important issue. If it's not going to hit the floor of the Legislature by the 8th, then we may not do justice to a bill that requires a more fulsome—she has several of her constituents from Ottawa travelling a great distance who have serious concerns about this bill. That may not be of concern to Ms Gigantes—or maybe Ms Gigantes is concerned about that—but I frankly feel we should have gotten some clearer indication that even the House leader for the government had encouraged the member and whoever is the subcommittee chair for the NDP on this committee in order to indicate that this was a priority for the government. All I have to work with is Mr Silipo's statement in the Legislature and before the estimates committee that it is not his government's priority. That's all I have to work with.

**The Chair:** Thank you. Mr Martin, did you wish to comment?

**Mr Martin:** Yes. Just suffice it to say, Mr Chair, that we wouldn't be here today if the House leaders hadn't agreed to bring this forward and to allow us the four days that we have, and I would hope the members opposite would work with their caucuses and their House leaders to make sure that this thing actually gets back into the House and does get approved, because that's part of the process here. That's been my experience, Ms O'Neill.

I'd also like to say to Mr Jackson re his smirk comment—

**Mr Jackson:** It's your smirk.

**Mr Martin:** It's a lot of crap, that's what it is. I got out of my sickbed this morning in Sault Ste Marie to be here today, and I've worked very hard at getting this piece of legislation to this stage and it is not with any degree of smartness or smirkiness that we all sit here today, I think, in support of this. We recognize how strongly felt the emotion is out there in the adoption community, and we're willing and wanting to do everything we can to move it forward.

As far as his own bill is concerned, I think that's, in my mind, completely out of order here. That's not what we're dealing with. There was an opportunity at subcommittee. I was ready to talk about his bill, but it wasn't brought forward. I don't know where it is or what it's about or where it's going, and I don't know why he raises it today.

**The Chair:** I think, as we saw in accepting the subcommittee report, we have set out our order of business and the next matter on that order would have been Mr Jackson's bill, so that we set this process out. I have to say that the members have expressed their views on this in terms of it being dealt with this session, and

I'm sure Mr Martin and others will take that back to the government House leader. But in terms of moving on, I think we do have representatives from the two ministries and we should proceed to their technical briefing.

I want first of all, on behalf of the committee, to thank you for coming today. I think we thought there would be some usefulness in really having a sense of just what exists out there today and then how this particular bill, with the amendments, would change that. If you like, one of the things we're after today is a kind of public education and education of ourselves on just how the system functions.

It has been noted that the representatives from Community and Social Services are going to talk about the people part, and from Consumer and Commercial Relations about the process part. I want to hasten to add that it's not because we think those of you from Consumer and Commercial Relations are not any more "people" people than are the people from Comsoc, but perhaps with that in view, what might be the best way to proceed, Mr Martin, would be if we asked the representatives from Community and Social Services, if that is the way you sort of have organized your presentation.

If you would go ahead and provide us with the information that you have prepared, then we'll open it up to questions and we can take it from there. Does that fit in with what you thought you were going to be doing? And if you would also please just identify yourself when you go to speak, for members of the committee and the television audience and for Hansard, we'd appreciate it.

**Ms Joan Belford:** I'm going to start off this afternoon. My name is Joan Belford. I'm from the Ministry of Community and Social Services. I have with me my colleagues Patricia O'Brien, from the adoption register itself and John Calcott from our legal services branch, as well as my colleagues from the Ministry of Consumer and Commercial Relations.

1610

I've been asked to explain to you what the current system is for adoptees to find information about themselves and for birth relatives to find information about the adoptee. I'm going to go through that fairly briefly and then tell you a little bit about what we think the system would look like if Bill 158 goes through.

**The Chair:** Sorry to interrupt, but just so I'm clear, this document which we have in front of us you will come to in terms of how it would change.

**Ms Belford:** That's the next one. This one's in the middle of your package.

**The Chair:** Oh, right. Okay.

**Ms Belford:** I also have a written description and some statistics here that I can distribute later, so you shouldn't need to take extensive notes as we've got it copied out.

**The Chair:** Fine. The Chair is a little slow on what was in his package.

**Ms Gigantes:** I wonder if we could ask that this material be distributed now, because some of us can take a look at it so that we'll be able to ask a question while you're here; your time with us is precious.

**The Chair:** Fine. Please go ahead.

**Ms Belford:** Okay. The adoption disclosure register which is in existence now, and is also known as the ADR in many circles, is the mechanism by which an adult adoptee and a birth relative can gain information about each other. Both the adult adoptee and the birth relative in our current legislation may have non-identifying information that relates to the adoption. At the present time that's already allowed in the legislation, and that non-identifying information for the adoptee would usually include information about the birth parent. The nature of, "Well, your birth mother was 19 years old, she was a student, her social circumstances, financial circumstances, would not allow her at that time to keep you,"—etc. The kind of information that the birth relative would get would be that the child was placed with a family; father was a professional, mother was a homemaker, they happened to have two dogs and a cat, they lived in a rural or a city environment, that kind of thing, but no identifying information and no combination of information that could be put together to identify people.

The adoption disclosure register was set up in order to enable people to get more information than that if both parties consent. It is disclosure that works on mutual consent.

I'm going to go down the left side of the chart first. The adoption disclosure register is a unit that's set up at 2 Bloor Street West. There is an application form for it and a way of indicating your interest in entering it. The adult adoptee over the age of 18 may voluntarily register in that and a birth relative may also register in that. A birth relative, for these purposes, is defined as a birth parent or birth grandparent or birth sibling, and it doesn't matter whether the sibling has been adopted or not, they're eligible for this information, over the age of 18.

If both sets of these people register and we can match them up—a match is identified—as we go down the left-hand side, we then contact those people to tell them that the other party has registered and is interested in contact. The current legislation requires mandatory counselling to say to people, "This is what's involved in this situation; these are the kinds of things that you might expect," to try to give people some information about what is likely to happen should they try to get together. This is mandatory before any identifying information can be released. This is provided by either our own adoption unit or by any of the children's aid societies. We have 55 children's aid societies across the province which also can provide this kind of service.

Our counselling is done by telephone, in person or by letter. We've more recently started to provide more of the information by letter as a means of speeding up the process, because one of the things that we've been hearing from the adoption community is that they prefer counselling to be at their choice and to be there if they need it, but not to be forced on them if they don't need it. So the counselling we do at this point is very much of an informational nature. We'll go further than that at the request of the person receiving the counselling, but it is primarily informational in nature.

On the basis of that mandatory counselling, both

people must sign informed consents to the release of adoption information and must formally enter the register. At that point, the identifying information is released to each of the parties, and the people can then proceed to reunion. Sometimes we can facilitate that for them, if they want to. They have the information where they can get together by themselves, if they want to. If one of the parties is outside of Ontario, it is our responsibility to find an appropriate social service agency in the other jurisdiction that can provide the mandatory counselling before that information can be released, or we can do it ourselves by long-distance telephone.

On the other side, on the right-hand side, if there is no match identified—I have some statistics for you on both sides of this that I'll give you in a minute—if only one of the parties is registered, there is now a differential in how those two parties are handled. If it is the birth relative who has registered but the adoptee has not, that is the end of it for the birth relative; they must wait for the adoptee to register. However, if the adoptee registers and the birth parent is not registered, the adoptee can request the ministry to do an active search for the birth relative. They may ask for us to search for any of the designated birth relatives. In most cases, they ask for their mother first and sometimes, if they can't find the mother, will go on to the father and sometimes a birth sibling. Some children who were adopted a little bit older and know they have birth siblings will ask for the birth siblings right from the beginning.

When we do a search—our adoption unit does that—we have access to some information but not all government records. For example, we don't have access to welfare records, we don't have access to health records. We do have Ministry of Transportation records and a few other records, and we do have access to some of the marriage and death records at the Ministry of Consumer and Commercial Relations. We work quite closely with them to try to track down the people.

If we find the birth relative, then the birth relative has a choice at that point. The contact with the birth relative would be quite discreet. We are aware that many birth relatives have not told anyone that the adoptee exists and the contact is quite discreet. The birth relative at that point, after some counselling or asking questions, whatever, may deny that they are the birth relative. They may acknowledge that they are the birth relative but they're not going to provide any information. They may choose to provide updated information, give updated medical information, updated information about the rest of the family but say that they will not release any identifying information. Finally, they may fully enter the register. In that case, they would proceed as if we had a match over on the other side.

There are a number of cases where we can't find the birth relative or we know that the birth relative is deceased, or the birth relative is located and found to be mentally incompetent. At that point, our registrar of adoption information has the discretion to release the identifying information from the original adoption order only. That's information that's as old as the adoptee is, so it's somewhat out of date. Any information that we've

gained in the process of our search is not allowed to be released at that point.

I have a couple of statistics here.

**The Chair:** Several members of the committee had some questions. Do you want to wait until we have finished this section and then come back? All right.

1620

**Ms Belford:** I don't want to give you a lot of statistics, but I want you to understand what is going on with this register. There's no fee for any of the services of the register at this point.

We did a survey in 1990 about people's satisfaction level with the current process and what we found was that people who had actually been through the process were quite satisfied with it. They found the counsellors sensitive and helpful and found the process quite satisfying. However, the waiting lists were considered to be intolerable, the length of time that one has to wait.

At the current time, and this is as of the end of the month of October 1994, the number of adopted persons who are on our register is 23,779 and the number of birth relatives registered is 16,160. Altogether, we have nearly 40,000 names on the register. Some of those people have been matched; we've had 7,417 matches. Each match involves at least two of the people on the register; in other words, there are sort of 15,000 combinations there. Most of those would be an adoptee and a birth relative, although sometimes it's a person with another adopted sibling, which can sometimes happen, and sometimes it's one adopted person with more than one birth relative. It's not an exact correlation, but approximately 15,000 of those 40,000 people have got some level of satisfaction, so there are another 25,000 people there who have not had their needs met.

The total number of search requests that we've received in that time is close to 17,000—16,926. Of those, 5,772 are completed and 287 have been withdrawn. As you can imagine, it takes a considerable amount of staff time to do a search. Some of them are done very quickly; we can find the person quite fast. But others take a long time before we can give up on those. At this point, we have 10,867 people waiting for searches.

Our average number of applications: When we first started this system, we felt that there would be an influx at the beginning and after that the number of applications would go down. That hasn't happened. The number of applications has been at least steady and in fact continues to climb. We're receiving an average of 392 applications per month now.

As of October 1994, our waiting period for initial processing is—we're doing it on the same day now. We've improved on it, we're doing better on it, but it still takes up to one year at the moment—it will probably be reduced to about six months within another month; we've just put some more staff in there—people are currently waiting one year right now to identify whether or not there is a match. That involves a process of going through our records.

When we've got two sets of circumstances that look like they might match, then we've got to go back to the

actual records and check out whether there is enough identifying information to make sure those people actually do match. So the waiting period just to find out if there is someone waiting to meet you is a year, and the waiting period for a search to begin is currently six years.

**Ms Gigantes:** The application that you're accounting for here is an application for what? Is that all applications? Does that include non-identifying information or does it include only people who want to register or only people who want a search? Who does it include?

**Ms Belford:** Which chart are you referring to?

**Ms Gigantes:** The material that you just handed around, to which you've just been referring, the average number of applications received per month—applications for what?

**Ms Belford:** That's an application to be in the register.

**Ms Gigantes:** So that doesn't include anybody who simply is asking for non-identifying information?

**Ms Belford:** No, that's another workload. With most of the people who are asking for non-identifying information, the workload will be at the children's aid society level, because those are the people who have the records.

I forgot the health/safety/welfare searches. In the middle of that diagram, there are health/safety/welfare searches. Under the legislation, if any person, and this is either an adoptee or a birth relative, has a significant concern that requires immediate contact with the other party, then under the health/safety/welfare clause we can do an immediate search for that person. When we do that, if we contact the other person, ordinarily what we need primarily is information, and it's usually medical information that we need. In some cases it may be that actual contact is needed; there may be something like a bone marrow transfusion or some rare blood kind of situation. But in most cases it's medical information that is needed.

Pat just gave me an example today of a person who had been adopted who has given birth to a child with a genetic defect. They are now considering whether they ought to have another child or not and it's really critical to know what the birth information is in order to do that. We would move that ahead on the health, safety, welfare clause and look for that person ahead of other people.

**Ms Gigantes:** Can I ask one further clarifying question on this information?

**The Chair:** Please go ahead.

**Ms Gigantes:** You've referred to the waiting period for researching, and that's after the application has been processed. It takes, on average, a year for the research to begin. But then it says, "Waiting period for a search to begin." Where is the gap there? You get the research done and then what holds up—just the backlog?

**Ms Belford:** The research will identify whether or not there is a match. If there's a match, then that can start down that channel and proceed there.

**Ms Gigantes:** But the research itself doesn't take a year? I'm trying to understand what you're indicating here.

**Ms Belford:** It's taking us a year. Because of the

backlog we have, it takes us a year to get the initial information, get it processed on the computer and identify whether there's anybody who looks like a match and then start going through the records.

**Miss Patricia O'Brien:** The research that we're talking about with an application—

**The Chair:** Sorry. Can I just ask if you would be good enough to introduce yourself for Hansard.

**Miss O'Brien:** Sorry. I'm Pat O'Brien. I'm the assistant registrar working in the adoption disclosure register.

The research that we're referring to there with the new application is researching our ministry records to find out, in the case of the adopted person who's registered, who were the adopted person's birth parents and that kind of data which goes on to the database in order to identify a match. The search is when we go beyond our records and actually go out literally looking for the person, the birth parent, say. We would then do an active search to try to locate the person, where the person is today, so we can contact the person and ask if they want to enter the register.

**Ms Gigantes:** I'm having difficulty moving from the point where the processing has been done, where there's no backlog, to the point where the research begins, where you'd know right off the bat whether there was a name or not on the register.

**Miss O'Brien:** I'm not sure I know exactly what you're saying, but when an application comes in now, we can put the information that the person has put on the application—the person can only put half of it on because they don't know the other half—into the computer and perhaps it will show immediately that there is a possible match and the other party is registered. If that shows that way with that minimal information, we will immediately proceed to check it out further and maybe that will identify a match. If—

**Ms Gigantes:** No, I'm lost again.

**The Chair:** I'm sorry. Perhaps we could come back. As you can hear the bells ringing, we have to go up to the House for a vote. It's not going to take us too long, but if you would kindly wait, we will be back. The committee stands adjourned until—

*Interjection.*

**The Chair:** Yes, you can leave your stuff. We'll be back in a few minutes. The committee stands adjourned.

*The committee recessed from 1629 to 1642.*

**The Chair:** The standing committee on social development is back in session. I think I can assure everyone that that was our last vote for the day, so hopefully we won't be interrupted. Perhaps we could pick up again where we left off. Might I ask, Ms Gigantes, if you perhaps, just for all our benefit, could restate the question, so we can get back into the substance.

**Ms Gigantes:** I think our experts have a handle on my question. My gap in understanding falls between the processing and the period of wait for researching to begin and, once researching is undertaken, why it takes six years. In other words, I'm trying to understand what it is

that's creating—aside from the backlog, what actually happens in the research?

**Miss O'Brien:** The first thing is the volume of applications. They pile up because the staff can't deal with as many as come in. They have to manually research these records. The old records that we have dating back to the early 1900s are not computerized in any way; they're on microreel. First of all, they have to go back through a series of index cards that are on microfiche, depending on the era where the things are. It's a very labour-intensive situation. They go back, they think they've found the right record from what information they have, they get the microreel out, they go through it and if they're lucky the record is right there where it should be. If they're not lucky and it's not there, then they have to go back to square one and start over again.

We also get in applications from people which are incomplete, so they have to go back and get more information from them. We get applications from people who think they're adopted but aren't, which we find out after we do some researching. We get applications from people who were adopted in another province, and when we look through our records and can't find anything, it's then that we'll go to the registrar general's office if the person was born in Ontario, because it will have a copy of the order from another province.

So it's the fact that the old information is not easily accessible—you have to go through a number of steps to locate it—plus the fact that we have suffered from lack of staff.

**Ms Gigantes:** Has there been any improvement in terms of the experience of using those records? In other words, as the experience of the ministry builds up using the records, is it possible to get those records into a shape that makes them easier to use?

**Miss O'Brien:** We've looked at that. We've looked at bringing them up to speed in terms of technology. It's not cost-efficient. It's just too much. I think the staff who have been there for some time are better able to spot difficult ones more quickly. They're able to sort of zero in on where to look for what we call the hard-to-finds. But I think what we have done right now is brought in a lot of extra staff to get through this backlog and to try to get it to a point where the permanent staff will be able to cope with what is coming in the door within a couple of months.

**Ms Gigantes:** When you say, "We're beginning research"—

**The Chair:** Ms Gigantes, sorry, can we just have the last—

**Ms Gigantes:** —and you say, "We're beginning a search," what's the difference between those two things?

**Miss O'Brien:** Between a search and the research?

**Ms Gigantes:** Yes.

**Miss O'Brien:** The research is when the application first comes in and the adoptee has put on their adopted information. The staff person, when they get the application, goes back to the old records. They find out who the birth parent was at that point. That information gets on to the database, and it may show a match or it may not. If

it doesn't show a match, then the application sits there.

The search is when we actively go out and look for, say it's the birth mother of the adoptee. We would then start with the records of the registrar general. We'd go through that. We'd try deaths, marriages, current addresses, MTC, that sort of thing, and hopefully find the location of the person today, make contact.

**The Chair:** Sorry. We've got two presentations, and I wonder if we could just go forward and complete the Community and Social Services and then we'll take any further questions on that part and then we'll move over to Consumer and Commercial Relations. But with the interruptions we've had, I'm afraid time is marching on.

**Ms Belford:** Okay, that's the basic system as it exists now. I'm now going to talk briefly about how we think the system would look if Bill 158 goes through.

Under the proposed system, this is very much a cooperative effort of the Ministry of Community and Social Services and the Ministry of Consumer and Commercial Relations, and in particular the Ontario registrar general, otherwise known as the ORG. In this scenario, we have divided the work primarily so that MCSS deals with the people—the inquiries, the questions, any counselling that's going to be done—and the registrar general will deal with the processing of the applications and the matching of files and issuing of files. In this scenario, people would first probably come to us. Anybody in the general public who has a question about what's going on, any adoptive families, any of that kind of question, would come to our adoption unit and we would have counsellors there who would deal with that.

When we talk about the birth parents, under the legislation that is proposed the birth parent would have the right to lodge a no-contact notice, which is a notification that this birth parent does not wish to be contacted. Under the proposed legislation, the adoptee would have the right to the information that's on his original birth registration regardless of whether the birth parent approves of that or not. That would be done without question to the birth parent.

Now, on that original birth registration, the most pertinent information, it would have the name of the birth mother at the time that the child was born, her address at that time, her occupation, if any—in many cases it was student—and the name of the hospital where the child was born, and it may have the name of the birth father if he was registered. There aren't all that many of them where they are registered. I think we estimated, what, about 15% at the most—not very many. There could be some other bits of information, a bit of information about the birth. The one thing that might be relevant to the adoptee is that it would say on that information whether this is the first birth to this young mother, and if it wasn't, that may give the adoptee a clue to go looking for a sibling somewhere.

1650

But basically it is information that is as of the date that the child was born. So it's as old as the adoptee is when he comes to look for the information.

That may give the adoptee enough information to be

able to find his birth parent and it may not. Much depends on how big a town he was born in, how unusual the parents' name was, whether or not he's able to follow through a change in name. Many of the women change their names at marriage, and this does not give them access to marriage records or death records. So there are still some obstacles in the way. But sometimes by using street directories and information from people in the town and whatever, they can be able to track things down.

The birth parent can come to us and say: "I don't want that person to contact me. I don't want the adoptee to contact me." The birth parent will come to us and ask us, "What do I do about this? What does a no-contact notice mean? What are the implications of it? What's involved in filling out the forms and making the application," etc, and we would try to explain to the person what that means and what the implications are.

The implications for the birth parent are that the adoptee would be prohibited from contacting the birth parent directly or indirectly. However, the no-contact notice can only apply to a person who is named on the original birth registration. So it can only apply to the birth mother or the birth father if named. It doesn't apply to aunts, uncles, cousins or anyone else in the family, and one of the things that we would be doing at our office is saying to people: "You have this option. You can place the no-contact notice. You may also wish to enter the register. You may have more control over the situation that way by having an intermediary in the relationship, if you want to do that." However, we would help them understand the implications of what they're doing and help them complete the forms if that's what they need to do.

We would be setting up a 1-800 line and we would have counselling staff available. We envision that the children's aid societies would also be able to help out with people in this regard, so that would make it available in more places and for people.

Now, one of the things about the birth parents is that many of them do not want to do anything which will identify them, so they don't want to go to people in person. They would be happier talking on a 1-800 line. They don't want letters of confirmation going back to them or they don't want anything that would identify them. So there has to be a way they can talk to us more or less anonymously at least at the beginning, which is the purpose of the 1-800 line.

When we get an application from a birth parent to file a non-contact notice, we would send that over to the registrar general. We haven't worked out all the details yet about how we would do that, but we envision sending it in batches specially marked, because with the volume of material and applications that the registrar general gets, we want to make sure that these receive attention immediately. The registrar general would then go through their files and try to match up the application of this birth parent to the birth registration it connects with. When that has been done, they will notify us that that has happened and we will have it confirmed, so that if a birth parent wants to phone somebody to check—"Did you find the file and was it correctly matched up?"—it would be our

office they would get in touch with.

I'm trying to follow along with the handouts we just got today, and it's talking here about "birth relatives (grandparents, siblings, and persons 'as if' birth parents)"—and I don't know what that means—"still can indicate contact interest," even if there's a non-contact.

**Ms Belford:** That's through the existing adoption disclosure register. I'm glad you brought that up, because I should have said right at the beginning that we envision the adoption disclosure register continuing to function for birth relatives. Birth relatives will not have the ability to make contact through the new proposed legislation, so the register would continue to exist for them. It would continue for those persons who find that it isn't enough information for them to locate their birth parent and they still need the assistance of a search, and it would also continue for the purpose of the health/safety/welfare searches when something has to happen quickly and we can do it faster than they could.

**Mrs O'Neill:** What's an "as if" birth parent?

**Ms Belford:** It's a person who may have raised a child as if it was their own child and eventually the child was placed for adoption or—

**Miss O'Brien:** The other time we've used it is if a birth mother, say, is deceased and her sister contacts us and says, "My sister had a child and is now deceased; I'd be very happy to meet that child." We have a number of maternal aunts or paternal aunts who are registering in that way. It's somebody who can give the adopted person the family background the birth parent could have given had the birth parent been alive.

**Mrs O'Neill:** But there's likely nothing legal in the way of guardianship that that person possesses?

**Miss O'Brien:** Not necessarily, no.

**Mrs O'Neill:** So you have to take their word or—

**Miss O'Brien:** We ask for some kind of identification to show the relationship to the birth parent.

**Mrs O'Neill:** Thank you.

**Ms Belford:** The adult adoptee will be applying directly to the registrar general for their original birth registration, and if the registrar general go to their files and they find that there's nothing there to indicate that a no-contact notice has been filed, the registrar general will simply issue that original birth registration. Our counselling services would be available to the adoptee if he has any questions or any issues that he wants to raise, but we envision it as being a fairly straightforward process. The adoptee applies there, they get the birth registration and they go on from there to do whatever they want to do with it.

However, if when the registrar general checks their files they find out that a no-contact notice has been filed, they will still issue the original birth registration to the adoptee but they also will notify the adoptee that a no-contact notice has been filed. We are preparing a standard piece of information that would go out with every one of these notices that would say: "This is what a no-contact notice means. It means you can't contact people and this is why."

We also envision asking the birth parent to write down the reasons why they don't want contact with the adoptee and allowing the adoptee to have that information. The experience in other jurisdictions has been that where a birth parent gives those reasons, it is more likely to be respected. If a birth parent is saying something to the effect of, "My husband and my family don't know that you exist, this has been a family secret for many years, my life would be shattered by this," then people tend to appreciate that more and will avoid the contact, or at least experience in other jurisdictions has shown that. The adoptee also is reported in these other jurisdictions to really appreciate seeing something that is in the birth parent's own handwriting.

**Mr Jim Wilson (Simcoe West):** Could I just ask a question? I guess two questions. One is, is there no computer-linking capability between the registry and the registrar general's office?

Secondly, we've received a number of letters asking that the proposed legislation be amended to treat all three parties equally, that being adult adoptees, birth parents and adoptive parents. Do you want to just comment on why the proposed legislation doesn't go all the way to meeting that request and why you're still keeping the current separate registry for at least one of the parties, the birth parents?

**Mr Bob LeClerc:** My name is LeClerc, from the Ministry of Consumer and Commercial Relations. I'd like to deal with your question about the linking of the databases.

The records for adoption are sealed. They are not in any sophisticated technological form. It would not be possible to computerize them. It would not be cost-efficient. There are over 200,000, I understand, adoptions on record. So when we get a no-contact notice, the office of the registrar general will have to search through these records manually, find the match and make the match against that record, but it's not possible to share the whole record with Comsoc and automatically do the kind of matchup that would be nice in a modern, computerized environment.

**1700**

**Ms Belford:** In regard to the second question as to why the bill only goes as far as it does, a number of options were discussed at the time we were first considering this legislation and the decisions were made at the political level as to which options would be pursued. Each level gets a little more complicated. When we did the consulting with some of the advocacy groups and the people working in this field, I couldn't honestly say there was universal agreement on anything.

The one on which there was the closest to universal agreement was changing the counselling component from mandatory to voluntary, and that was very highly accepted. The next level of acceptance was the proposal more or less as it is now, that the adoptees would get the right to their birth information. When you go to the level of the birth parent getting information about the adoptee, it's impossible to give information about the adoptee without also releasing information about the adoptive family, so you get another set of actors contained in that.

The other complicating factor in that is that some of the children who were placed for adoption came from abusive families and there would be further policy questions raised then about, would there be classes of people you would screen out from having access and would the fact that a family was abusive 20 years ago mean that they still represent any kind of threat to the family? There are a number of more complicated policy issues that would have to be considered in going to that extent. There are also a number of other complicating factors that come up with—there was a whole range of options that were presented, and the final decision was made at the political level as to which option would be pursued at this time.

**Mr Jackson:** Just for clarification, what do you mean by the political level?

**Ms Belford:** Well, I believe Mr Martin made the decision about what he was going to pursue.

**Ms Gigantes:** Can I ask of other members, just to follow on that—

**The Chair:** I appreciate that and I know as we go in there are many questions. I want to allow as many as I can but just say to members that we will want to reserve at least 15 minutes for the Consumer and Commercial part. I chatted with the officials beforehand, but just so you're aware, not yet but at some point I'm going to have to jump back in.

**Ms Gigantes:** If we have 200,000 records which are not in computer-friendly form, are we changing the way we collect those records now?

**Miss O'Brien:** In our unit, the placement of children has just now gone on line on computer.

**Ms Gigantes:** What about at children's aid societies?

**Miss O'Brien:** The placement is registered through the children's aid society to the area office, which now has the capability of putting it right on line to us. So that will replace the old index cards we used to have to flip through to find a record. That's very new, but that will help in 18 years' time.

**Ms Gigantes:** That's great. Thank you.

**The Chair:** Mr McGuinty, did you have—

**Mr McGuinty:** Not directly, Mr Chair, but I'm afraid the time will go on and I won't have an opportunity to ask this. I guess the first question I have is some consideration of the reaction to an adoptee when they encounter a no-contact notice. I'm not fully acquainted with this issue, but the people who have written to us to date express a very strong desire to be able to contact birth relatives. I'm wondering how strong that is, and is it so strong as to be unreasonable for us to expect that they will be able to abide by a no-contact notice?

**Ms Belford:** I'm afraid we can only answer that on a speculative basis. We will have to see what the experience is in Canada. We can only go on the experience of other jurisdictions.

I think, as some of the members said earlier, this is a limited bill; it is only going to a certain extent at this time. Adoption is evolving, and I think it's going to evolve further in the next few years. There have been

tremendous changes in it in the last 20 or 30 years, and there are probably going to be many more.

We are recognizing that the adoptee who is faced with a no-contact notice may be very upset and stymied by that. That is why there's an arrow going back to the Ministry of Community and Social Services for more counselling that would be available to adoptees who receive a no-contact notice.

Again, the experience in other jurisdictions is that this has been respected to a high degree. The adoptees have an overwhelming desire to know, or at least the ones who are looking. I think one of the things we have to keep in mind here is that we don't really know how many people are going to use this; I think a lot of people will. The highest uptake they've had in the initial year in any of the jurisdictions that we've looked at so far has been 11%, and we're predicting 15% here as a bit of a safeguard. But as much as they have a deep desire to know, they also have a deep-seated fear of rejection. If they've got an indication that the birth parent does not want to contact them, then they have to deal with that as well. Are they willing to risk everything, more or less, to be rejected again?

Sometimes the reason that a birth parent may not want to see the adoptee may be enough in itself. We have some situations where the birth and the whole situation was not a very pleasant memory for some of the birth parents who are involved here. Sometimes when an adoptee understands those reasons they may not want to pursue it further.

I think we're going to have to wait and see what happens when this goes through. We know what's happened in other jurisdictions, but Canada is not entirely the same as everybody else, so we can't tell completely.

**Mr McGuinty:** This is my final question. You've been involved in searching for birth parents. They can be found virtually everywhere. Have you been able to project as to what percentage of our birth parents will be made aware that this legislation, if it becomes law, is now law, and that if they don't want to be contacted they have a period of time within which to do that? How many are we going to hit? How many are we going to be able to cover?

**Ms Belford:** We're planning a communications campaign to try to get that message out to as many birth parents as we can so that those who want to file that kind of notice can do so.

**Mr McGuinty:** Will it be a Canada-wide campaign?

**Ms Belford:** It will be Ontario-wide to start with. There will be notices to all of the other provinces and any of the border states. We are going to use the members of the adoption community to get that message out as far as we can. We're expecting that there will actually be a fair amount of publicity about this legislation, should it go through, that will be picked up in a number of jurisdictions and that will cover that, but we will have official notifications that are going to all of our counterpart agencies in all of the other provinces and the States, for sure. There are some key people that we're in contact with in Australia, New Zealand and Britain whom we

will certainly make aware of the legislation. To conduct a Canada-wide campaign is just prohibitively expensive. It will certainly be extensive in Ontario, but to go Canada-wide is prohibitive.

**The Chair:** I'm sorry, but my mind is on the clock. Perhaps we could just complete your part of the presentation, and then I'll ask your colleagues to—

**Ms Belford:** I think I've pretty well covered the way we've seen it. We have a much more detailed comparison of the current adoption disclosure registry and what would happen under Bill 158, which is in the package of material we gave you today, but I think it would be sufficient for you to read that.

1710

**The Chair:** We can come back to further questions, but for the record I'd just like it if we could get the officials from the Ministry of Consumer and Commercial Relations to set out their part of the puzzle, and then we can all come back to the full issue.

**Ms Gigantes:** Put me on your list for after.

**Mrs O'Neill:** And myself also.

**The Chair:** Okay. Again, if you'd just be good enough to introduce yourself.

**Ms Judi Hartman:** My name is Judi Hartman. I'm with the Ministry of Consumer and Commercial Relations, office of the registrar general in Thunder Bay. We have this much snow this morning, so I'm very glad to be here.

Joan has already generally described the how, the process by which this bill would be implemented should it pass third reading, royal assent and proclamation. I think it's important just to go back to a point Mrs O'Neill made earlier; that is, it is a very complex bill in that it deals with two different ministries, two different statutes and a community or a group of stakeholders who've been frustrated for a very long time.

We've worked very exhaustively over the last while to try and work out how it would be implemented, how we could get people the information that they want and need as quickly as possible. That is what led us to the amendments that Mr Martin circulated to everybody last Friday.

The intent of the bill as it was originally drafted has not been changed in any way by the amendments. The amendments that we've suggested deal strictly with administrative matters, technical matters that allow us operationally and practically to get this going as quickly as possible after proclamation. Things like where the birth parent would go to for information, moving that over to Comsoc allows us to get on with the business of moving the paper and getting people the information that they want as quickly as possible.

The office of the registrar general, as I'm sure many of you are aware, isn't resourced to deal with the increase or the volume of queries that will probably result from the implementation or the proclamation of the bill itself. So Comsoc has graciously said that it's willing to talk to people and educate people and communicate all of the roles and responsibilities to anybody who asks, and we'll get on with the business of matching up the no-contact notices with the original birth registrations and then

handling the applications from the adult adoptee.

In your package today, there is a description of how the amendments are reflected in the original bill. If you look at it, the title is "Comparison of Bill 158 and Recommended Revised Language." I won't go through each of them individually, but suffice it to say if you look down the right-hand column, there is no change in substance whatsoever; clarifications, some change in form, just putting words in different statutes that allow us the flexibility to do the actual business of releasing the documents.

I'll give you a for instance. We need to unseal all of these 250,000 records. Now, there's a question: Do you unseal them one at a time as people apply or do you try to get a jump on the business and unseal them all and work through them ahead of time so you're prepared for people and you don't have backlogs right off the bat on day one? So providing for some unsealing language will give us the operational flexibility to meet the demand as soon as it's there rather than making people wait any longer than they've already had to wait.

I don't want to take any more of the committee's time. If there are questions, I'm happy to entertain them.

**The Chair:** Fine. Then I'll go back to the rotation. I have Ms Gigantes and Mrs O'Neill.

**Ms Gigantes:** I know that it's in our material somewhere, but I've missed it, and I'm looking for it again. What is the date of our existing legislation?

**Miss O'Brien:** It's 1987 for the amendments for the disclosure register.

**Ms Gigantes:** Can I go back to the figures again on the adoption disclosure register statistics. I'm still groping here. I'm looking at the sheet that is headed with that title. If I understand it, the "Matches on the Register," which is the fourth notation down, 7,417, are the people who, once you begin the research, everything goes jackpot, they're both on the register. So that's roughly 15,000 happy people right there. When we look under the sixth notation, completed searches, are those all matches or are those searches that you've taken as far as you can get?

**Miss O'Brien:** They could be searches where there would not be a match because the person has been found deceased. They could be searches where we couldn't find the person. They could be searches in the health, safety or welfare area. Some of them do not go on the register because we do searches on behalf of minor adoptees where there's some medical reason why we have to find the birth family. They would not be counted. There are searches that we do where we find the birth relative and the birth relative chooses not to register but maybe only supplies some non-identifying information or may in fact refuse to get involved.

**Ms Gigantes:** So we don't know in that group called "Completed" how many are what I'd call happy endings and how many are frustrated endings?

**Miss O'Brien:** No, we wouldn't be able to give you an answer through this. They're two different sets of figures.

**Ms Gigantes:** Is it possible to get that?

**Miss O'Brien:** Pardon?

**Ms Gigantes:** Is it possible to get that information?

**Miss O'Brien:** We have not kept statistics on a case-by-case basis on how many have registered as a result of a search, unfortunately. We just didn't have the capability to do that, other than spending a lot of time doing searches. We have done a couple of surveys, and I think the feeling is that in about 65% of the searches the person does go ahead and register. But I can't give you an exact figure.

**Ms Gigantes:** Could I ask whether bringing all this information on line—and I know that that's talking about information entering the system at a different place—now that our system really is becoming computerized, whether it is possible from here on in to collect that kind of information?

**Miss O'Brien:** That was the intent when we started the computerization a few years ago, but unfortunately the statistical part did not get implemented or get programmed. I would hope that it will get there, but it's not right at the moment. We don't have the capabilities.

**Ms Gigantes:** So nothing about the changes we're bringing in would make that happen? Nothing about the changes we're considering in Bill 158 would help make that happen?

**Miss O'Brien:** On the computer system, you mean? I don't think so.

**Ms Belford:** Not directly, I don't think, no.

**Miss O'Brien:** I think that there would be a number of adopted people on our register who, when they've gotten the information on their birth registration, may decide to conduct their own search and find satisfaction through that method rather than waiting for us. But I don't think it will help us in terms of gathering statistics.

**Mrs O'Neill:** I have a couple of questions. I wanted to go, I guess, to the Consumer and Commercial Relations, so let's start with that.

I'm having trouble understanding the word "clarification" in that box, "Situations where No Contact Notice cannot be processed." I guess I just don't understand it at the moment.

**Mr LeClerc:** Perhaps I could help you, because I drafted this table.

**The Chair:** Just before answering, can you just tell us again which box?

**Mrs O'Neill:** I'm talking to the box that is on page 2 and is entitled "Clarification." It's rather embarrassing to have to ask a question on clarification on "Clarification," but I'm afraid I have to do it.

**Mr LeClerc:** In the original wording of the bill, it really didn't deal with this kind of a situation, a situation where you could not do a match. We have attempted in the revised bill to deal with that and to indicate that in the process if someone registers a no-contact notice and there's inadequate information when we go through our records to find the original birth registration, then we will advise Community and Social Services, who are acting as the window, and they will get back to the people and talk to the birth parent and say: "We need more information etc. We cannot do the match." So we tried to refine that.

That wasn't something that was strongly contemplated in the initial bill as a potential problem.

1720

**Mrs O'Neill:** So what you're saying is that a no-contact parent may also be unable to be matched.

**Mr LeClerc:** That's right. If I was a parent who had given a child up for adoption and I sent in a no-contact notice and somehow the information that I had didn't match anything that was in the records, then eventually Community and Social Services would get back to me and would say: "We've talked to the registrar general. We can't make that match. We can't find that record." There might be a number of reasons. I might be wrong in the names that I believe were recorded on the original birth registration. As Joan has indicated, possibly the original birth was not in Ontario and so we couldn't match it on that basis.

**Mrs O'Neill:** That's my first question. My second one has to do with unsealing language. What does that mean? You used that term.

**Ms Hartman:** Right now, the Vital Statistics Act provides for all of these records to be sealed and unsealed only when the registrar of adoption information inquires of the registrar general for information. They can't be opened—

**Mrs O'Neill:** No, I realize that. Do you have a section that you can point to where I can find the unsealing language, or is this going to be regulations?

**Ms Hartman:** We hope it would be in the Vital Statistics Act. So it should be part of the amendments that go around.

**Mrs O'Neill:** Have you got it here?

**Ms Nancy Sills:** I'm Nancy Sills. I'm legal counsel with Consumer and Commercial Relations. In the amendments that legislative counsel delivered to the committee this afternoon, there is a clause, a new subsection, that will specifically allow the registrar general to unseal registrations.

**Mrs O'Neill:** Could you give me the number of that, please?

**Ms Sills:** It would be section 29.1, in section 2 of the bill.

**Mrs O'Neill:** I just wanted to ask, are the courts involved in any of this at all, the individual court where the adoption was actually processed?

**Ms Sills:** Not in the contemplation of this bill, no.

**Mrs O'Neill:** My other question was, has the freedom of information officer had the non-contact clauses of this bill and examined them? I know that regarding adoption there are many exceptions, but I am concerned that this is a new and a big step, although in many cases a limited step, and I think that some of you have already indicated that there will be certainly an awful lot of interest about this bill. I guess I wanted to verify at the beginning that all channels had been checked, that there won't be challenges to this bill that haven't been anticipated. I haven't heard any of you talk about the freedom of information at all, and as I say, I know that there are in some cases exceptions related to it in the adoption

legislation that we presently have, but this is new stuff. So can any of you respond to that?

**Ms Belford:** We did talk to the freedom of information commissioner early on in the process when we were considering how any of the proposed options would be affected by the freedom of information act and were advised at that time that the information relating to an adoption is considered to be rather an exceptional circumstance and should be treated in that manner. That's what some of the amendments in the bill do; they define the information about the no-contact notice as information related to an adoption, which is therefore exempt from the FIPPA regulations. However, we have not reviewed that with the freedom of information commissioner in its final form, and we probably should do that.

**Mrs O'Neill:** I think that would be a good thing to do. You've already got punitive measures here if things are not respected, and I understand that they are not tested very often, but I think this bill should have as much protection as possible. We are talking about, in some cases, very old information and very confidential information. So I would feel a lot better if somebody could guarantee to me that this was run by the commissioner in its final form. Maybe we could have that done before the hearings are over. That's all at the present time, Mr Chairman.

**The Chair:** I have Mr Wilson and Mr Hope.

**Mr Jim Wilson:** I really do need a clarification here in terms of a follow-up to my previous question. As I understand, the proposed law would be that the adult adoptee can request the original birth record. At that point, or at some point, the only new right of the birth parent is to indicate yes or no to the no-contact notice. Is that right?

**Ms Belford:** Yes.

**Mr Jim Wilson:** So the birth parent's no further ahead in this new scheme. The new scheme just enhances the rights of the adult adoptee. Okay, and you did explain generally why there were some problems and that there really wasn't consensus out there about including equal rights for birth parents.

I just wonder if you would want to explain to me again: Under the new scheme, birth parents either get to say yes or no to a no-contact notice and they can withdraw the notice once, according to your amendments. But what about their right for identifying information, the original birth registration, for example?

**Ms Belford:** Their right for identifying information is not dealt with in this bill.

**Mr Jim Wilson:** It's just because I know we're going to hear a lot of that in the public hearings that start tomorrow, and unfortunately I won't be here tomorrow either but I will certainly be here Monday and Tuesday next week. Can you just, in a nutshell again, try and get through my head—I know the decision was made at the political level—what were major obstacles?

**Ms Belford:** There are advantages and disadvantages to giving the birth parent access to that information, but the first level, on the disadvantages, is that it is impossible to give information about the adoptee without also

giving information about the adoptive family, so you multiply the number of people affected right away. You've got the adoptee and the adoptive parents and any other members of that family who are also involved in the release of that information. That's one complicating factor.

Another complicating factor is that, although many of the children who were placed for adoption were placed by young mothers in circumstances where they really didn't have a lot of choice socially and economically about keeping their child, some of the children who are placed for adoption do come into the child welfare system because they are neglected or abused in their own homes. The question then becomes a little more complicated as to, do you have to set up various categories of birth parents who can have access? Do you say that only if you were an innocent teenager you get to have access to that information, or if there was abuse in the background that you don't, or if there's some kind of screening mechanism you would have to go through to see if you're a fit parent at this time or pose any risks to the child, that kind of thing. There's another level of policy work that would need to be done there to deal with that issue, which hasn't been done yet.

**Mr Randy R. Hope (Chatham-Kent):** Something Mr Wilson said was, do you only have one chance to reconsider a no-contact provision? Why would that be? You use the scenario that it's the young unwed mother who is maybe in school or whatever and has decided and is now entering a new life. The adult is now looking for the parent, makes one inquiry and the parent knows that the child is out there. The mind regenerates one more time; after progressive thinking, within a few years from now, after getting the new family accustomed to this child who was never known about, the option may come up one or two more times later on. I'm just wondering why it's only limited to one option.

**Ms Hartman:** It's purely a practical issue of issuing a copy of the original birth registration and having the veto coming in after you've issued it. If birth parents put the veto on the registration and the children apply for the registration and we give it to them with the veto, then we have to go and tell them that the veto's been lifted. Then, if the veto's put back on again, they've already got the information.

1730

**Mr Hope:** But I mean changing from the no-contact. Let's say, for instance, something stimulates another no-contact information form to go out and they're still saying, "No, I don't want this person to contact me."

**Ms Gigantes:** That's easy. Doesn't that just require the person to put the name on the registry?

**Ms Hartman:** The amendments we proposed would allow a birth parent to apply the veto and remove the veto once. If they come back and they want to apply it again, we run the risk of having already issued the—

**Mr Hope:** Okay. So you can still say "no contact" and you can also say "contact."

**Ms Hartman:** Mm-hmm.

**Mr Hope:** Once you've opened the file, you're now

open. If you've closed it and you reconsider to have it open, you have that option to reopen.

**Ms Hartman:** That's right.

**Mr Hope:** That's what I needed clear because I'm not familiar with adoption. I'm not an adopted child. I have natural parents. Some would question that, but I do have natural parents.

**Mr Jim Wilson:** It's not your fault.

**Mr Hope:** I know. But the thing is that I am trying to get a better understanding and you have to convince me. I'm asking the ORG to really convince me of this. I look at birth certificates and now you want to handle this system. Please convince me that this is going to work. I hate to bring it up, but as soon as you mention ORG, and we're talking about a very delicate situation, and I know the frustrations I go through with birth certificates, please tell me how this is going to be very successful. I really would like to hear it.

**Mr LeClerc:** We can tell you, Mr Hope, that right now we're running the average birth certificate at two to four weeks. There are some that take longer, but the average one is going two to four weeks.

The vast majority of birth certificates and other certificates are matched by computer. Where you can match your request with what's in the database, the computer goes boom, boom that night and we're home and cooled out. The problem is delayed registrations of birth, things like that, changes of names. They take longer. They take more human involvement. When you get more human involvement, it gets slower.

This system will not be computerized. It will take a while, but we're hoping that we can do it adequately and we're hoping that we can do it well.

**Ms Hartman:** If I can just add to that, it will be kept separate from the other registration business that the ORG currently does. These people's requests aren't going to be thrown in with all the requests for other types of certificates.

**Mr Hope:** Not so much just for myself; the general public does watch these proceedings and they know the frustrations. They yell at me about their birth certificates, and I think it's important for you, who are going to be working with the process, to convince them that it is a proper way of expediting.

When you talk about these sealed files and you're talking in the legislation where it allows them to be opened up, are you now talking about taking that information—I guess I was getting confused when Evelyn was asking questions and Mrs O'Neill was asking questions about this information that's in these sealed documents. You've got to explain it to me because I'm not familiar with the adoption process.

**Ms Hartman:** Right now, when a person's adopted, we receive a copy of the adoption order from the court where the adoption took place and we take the original birth registration and attach that order to it. In some cases, the court orders that sealed or the birth to be re-registered with the new name and the new parents on it.

When we say "sealed," the two pieces of paper are actually put in an envelope, sealed shut with an official

seal put over the slip of paper so you can tell if it's been opened, and they're filed manually in a filing cabinet area. They're sealed from our eyes as well as the general public's eyes. The staff at the office of the registrar general don't have access to them, with the exception of the adoption unit and the registrar general or the deputy registrar general.

What we need to do, so that we can prevent backlogs and more frustration on the part of the applicant, is to be able to work with these records in the year before people can apply for them. The year that birth parents are going to be applying for vetoes, we need to be able to open them and attach them and make sure we've got the right ones and do whatever searches are necessary and that sort of thing.

In working together in proposing the amendments, that's what they're meant to deal with, all those possible delays and problems in actually doing the manual work so we don't get people in a backlog situation.

**Mr Hope:** When you open these, they still stay in their paper form. You're not transferring them into a computer which is accessible, and when you're looking at the commissioner dealing with freedom of information and protection of privacy, I'm wondering if there's a way of entering this into a system that is just as sealed as a filing cabinet would be or a sealed envelope, which could be sealed in a computer system, which Mr Wilson and I believe Ms O'Neill were talking about where, instead of going through them hand over hand, you're now just entering them into a computer which has got a special code, which you can process in. Is that what you're talking about to help make this system work better?

**Ms Hartman:** For the committee's information, there are some adoption records that are on a computer system. As a result of the move of the ORG to Thunder Bay in 1991, we turned to a computer technology called auto-imaging to get rid of paper. Adoptions that have taken place since 1991 are imaged in that technology and the paper is available, but the adoption document is looked at on a computer system. We do have security accesses, so in effect it's sealed as if it were in an envelope. But there are about 200,000 records that aren't on the imaging system that happened before 1991. The cost of converting them is extremely high and we're just not resourced to do that right now. There is a potential for that to happen in the future, though.

**The Chair:** I have three people down, and just to note, members, time is moving on. I have Ms Carter, Mr McGuinty and Ms O'Neill.

**Ms Jenny Carter (Peterborough):** I just had one query. Is the no-contact notice absolutely solid, irreversible? I'm just wondering if there might not be circumstances where, in spite of a no-contact notice, it was still desirable or necessary to somehow get through to them and inform them of perhaps some change in the situation or something that either the adult child needed to know or they needed to know.

**Ms Hartman:** I think Joan can answer that.

**Ms Belford:** Yes. We can still handle that through our health/safety/welfare searches. What that does is it has a

ministry staff person in the middle who would approach the person who is being contacted and get the information that's required without necessitating the birth parent actually having contact with the adoptee. So we can still do that through our health/safety/welfare section of the adoption register.

**Ms Carter:** But I wondered whether sometimes a search was actually initiated for these people and it may be years after they made the original order, and perhaps if they heard that they were actually being sought, at that point they might want to change their minds.

**Ms Belford:** That's possible too. If we contacted them and they said at that point they would be willing to have contact, they would just withdraw their notice.

**Ms Carter:** So you would make that contact. I mean, it isn't just a barrier that goes up and all contact ceases.

**Ms Belford:** We could do it under the health/safety/welfare provisions on an emergency basis or if requested to do it on a search basis on whatever time line that takes us. We could do it under either one of those provisions; we could continue to do it that way.

**Mr McGuinty:** I wanted to revisit the issue I raised earlier. They both connect, I guess, with my concern that we may not be doing everything we reasonably can to properly protect the birth parent's right to privacy. What's built into this bill is I guess implicitly something that we'd call acceptable losses. That's based on two things that are going to happen here.

First of all, we're going to have adoptees obtain information together with a no-contact notice who will not respect that no-contact notice. I say that not in a pejorative sense or to be critical, but because of my basic understanding of this. This need to know can be so strong that it could virtually overwhelm an adoptee. You might as well take a man to the desert for three days and put a glass of water in front of him and say, "Don't drink it." I think it's an unreasonable demand to be made. The same might very well apply to some of our adoptees.

The second point is that there are going to be some adoptive parents who did not register because they did not learn about the new legislation. For that reason, they too could be contacted. There are many, many people in this province who do not read the newspaper. I gather that is going to be one of the primary sources of purveying information about the new legislation.

We've been able to project how many birth parents will be contacted either because people don't respect the no-contact notice or because they're not made aware of the new legislation, and we have something which I think is rather unusual in law: We're imposing a positive obligation on them. They have to come out and register a no-contact notice.

1740

The other thing, if I can throw this into the mix, is that being contacted when you don't want to be contacted I gather is something that is fairly traumatic and a major source of upheaval in your personal life. So we're talking about something here that's very sensitive, and the act, to my way of thinking, just says, "Those things will happen, but those will be acceptable losses, and when we weigh

them in the grander scheme of things, it is more important to create the new scheme." But I'm just wondering if, based on what I've said, you feel that we have adequately protected the rights of birth parents.

**Ms Belford:** I think the bill proposes a measure that is designed to provide some protection for birth parents. It is certainly not absolute. The problem with this entire situation is that you can't balance forever the rights of the birth parent and the rights of the adoptee. At some point you have to come down on one side or the other.

**Mr Jackson:** That's why it's such a foreign concept to politicians.

**Ms Belford:** The best way that we attempted to balance the rights of both people was by having the adoption disclosure register wherein there is an intermediary, there is discreet contact and there is an opportunity for both sides to consent to being together and there's not in this, as you say, a situation where there probably will be some birth parents who won't hear about the legislation even though we have considered quite a number of ways to reach the people who are most likely to be affected by it.

However, the adoption disclosure register just doesn't work. It would take us—I forget what we came up with—millions of dollars in order to have enough staff to process anything in an amount of time that would be anywhere near reasonable at all.

So in looking at the next-best thing as to where we could go from there, at some point or another you do have to come down on one side or the other. We have heard from a lot of birth parents, a lot of adoptees, a lot of adoptive parents. There are some people who are going to feel disadvantaged by this legislation no matter what we do or what way it was formulated. However, in what we heard from the people who made presentations to us, we had contact with a number of birth parents who were contacted by their adopted child without notice and without wishing to be contacted and who found the initial experience very traumatic. However, the trauma didn't last and eventually they were able to be reconciled to that notion.

**The Chair:** Just to be clear, you mean people who outside of the system went and found their parent?

**Ms Belford:** That's right, not using information they get from ourselves.

**The Chair:** Which continues and could go on irrespective of this system.

**Ms Belford:** Yes, and I think we should be knowledgeable that it is going on in quite a number of situations. There are all kinds of groups out there that will help adoptees search for their birth parents now and some of them are very good and some of them seem to have access to some records that we don't in order to get this information.

One of the disadvantages we have in trying to do some research and figure out what's going to happen is that there's no group of birth parents we can go to. Birth parents, by the very nature of their situation, if they do not want to be identified as birth parents, obviously don't join groups and don't come to public meetings and they

don't do things like that. The best way that we've had of hearing from them is when there's been something in the news media and then we've had reactions from people. Some of the stories we've heard from birth parents would break your heart. So would some of the ones from adoptees. It's a very emotionally charged situation for both parties, and I think in the long run you eventually just have to come down on one side or the other. This legislation comes down on the side of the adoptee with an attempt to provide some safeguards for the birth parent at the same time.

The other thing is that it is happening in other jurisdictions, and we have contacted the people there and have asked, "Have you had any lawsuits? Have you had any incidence of anybody being physically harmed or endangered in some way?" and we haven't had anything reported to us yet.

**The Chair:** I want to make sure Mr Martin can end it.

**Mr Martin:** I just wanted to say to Mr McGuinty that as the folks come forward tomorrow and next Monday, this discussion will be on the table, I'm sure, because it's certainly things that we've talked about as we've met. They will not talk about it as coming down on one side or the other; they will talk about it as levelling the playing field, of bringing them up to a place where they have equal access, as did their parents when the adoption first took place. They feel quite strongly about that and will use language that will indicate that this is something that actually turns around what they consider to be an antiquated system that encourages oppression, dishonesty and secrecy. So those are the kinds of things that I've heard that they will present, I'm sure, when they come forward. It will be interesting then for you to enter into that discussion with them, because really, some of the philosophical underpinning of this is in that question.

**The Chair:** Mrs O'Neill, you had a final question?

**Mrs O'Neill:** I was quite surprised to hear Consumer and Commercial Relations people suggesting this is not going to be computerized now, because we have just found out that the adoption and MCSS statistics and data are being. So there is no role for a computer in this whole process, is that what we're suggesting, because it's kind of the end of the story for the people who are going to be involved? There must be a reason.

**Ms Hartman:** I don't think we can say there's no role for technology in providing service to the adoptees. In the future, the records that have been already imaged or computerized will be available on a computerized basis. We haven't yet put in place any sort of process that we would use to provide these records. If we were resourced to a certain level, we could do that. That hasn't been worked out yet.

**Mrs O'Neill:** Okay. The other question I had, Ms Hartman: Could you say a little bit more about opening those seals? I'm sorry, I think that's very important, because people have been protected by the seals for a long time. You're suggesting you're going to now ask for access to do that before the no-contact actually clicks in. Can you tell us a little bit about what you're going to do and why you're going to do it?

**Ms Hartman:** I didn't mean to imply we were going to do it before we received the veto. We would do it at the point we receive vetos: go in, open the record, attach the veto to it—and that may be a physical piece of paper to a physical paper file or, in the case of a recent adoption, it may mean imaging or computerizing the veto to go with the computerized record that currently exists, but do them as they come in. Then we won't reveal them once the veto's attached. We will just leave them with security access on the computerized ones, and the other ones in a separate filing area for the time being, until the adoptee, or if—in the event that the adoptee applies. It just means that we don't have to put it in an envelope and put a sticker on the back and have somebody sign it again.

**Ms Gigantes:** Could I just say that, if I understand correctly, we shouldn't associate the sealing with protection of the birth parent necessarily, because the sealing may have been at the behest and at the initiation of the adopting parents.

**Mrs O'Neill:** Well, in case they're sealed, and they were sealed legally—that's a very fundamental point.

**Ms Gigantes:** Yes, but I don't want us to think that when we do the unsealing, what we're doing is removing the protection that existed because it was a protection desired by the birth parent. That may not necessarily be the case at all.

**Mrs O'Neill:** It was part of a legal process. It was nobody's intent to do anything to anybody. It was part of a legal process.

**Ms Hartman:** In effect, it was a mechanism that the courts used at a time when records weren't computerized so that somebody couldn't inadvertently spill the beans and disclose the information. They were sealed from our staff's eyes as well, so that they were handled in a sensitive manner.

**Mrs O'Neill:** Exactly.

**Ms Hartman:** Nowadays, with technology and with the Freedom of Information and Protection of Privacy Act, that sealing isn't necessary within the confines of our office, and unsealing them doesn't affect their sensitivity or the way they're dealt with in terms of the general public or adoptees.

**The Chair:** One final question from Mr Eddy and then Mr Martin, and then I want Ms Drummond to comment on some of the things she has given us and a few notes about tomorrow.

**Mr Ron Eddy (Brant-Haldimand):** My question then follows the last two questions about the sealing. I know adopted children who have copies of their adoption order. This is news to me that they've been sealed. Now, they would be sealed on orders of the judge, the court. Would they—

**Ms Hartman:** I'm sorry. The order itself isn't sealed. Just the original birth registration is sealed. The adoption order is, if you will, stapled to the outside of the envelope. Inside the envelope is the original birth registration.

1750

**Mr Eddy:** But the adopting order gives the birth name.

**Ms Hartman:** Yes, it does.

**Mr Eddy:** Of the child.

**Ms Hartman:** Yes, it does. It is not sealed from our staff's eyes. It is not available to the general public through our office.

**Mr Eddy:** Right. An adoption order is not.

**Ms Hartman:** No.

**Mr Eddy:** That means it's sealed, if it's not available. Or is that a different type?

**Ms Hartman:** Sealing is a technical, legal term.

**Mr Eddy:** Okay, just from your eyes even.

**Ms Hartman:** It doesn't mean anything. It's not sealed in any way to us.

**Mr Eddy:** Okay. Thank you.

**The Chair:** Mr Martin, did you want to just make any final comments, because there are a few other—

**Mr Martin:** Just to thank the ministry folks for coming forward and being so informative and frank and helpful. So far, this process has been a discussion between those of us who live and work here. Tomorrow and next week we will hear from the people themselves who are directly affected. That will add another whole perspective to this process which will be rather interesting and helpful. I think any of us who are able to be here will probably learn a lot and hopefully be able to ask a lot of good questions so that in the end we will all feel comfortable that we have a piece of legislation that at least takes us a step forward, if not the whole hundred yards, at this particular point in time.

**The Chair:** If I might also thank all of you for coming this afternoon. Clearly we are dealing with something that is very sensitive and in some respects very complex, but I think that it's helped us on the committee to understand both what exists and what the intention of the legislation is. I'm sure if there are further questions as we go through the testimony, we'll get them back to you and seek further clarification. But thank you all for coming before the committee today.

Before we adjourn, just a couple of things, committee members. First of all, tomorrow one of the witnesses is a Miss Katherine Kimbell, who sent us a book earlier in the year, back in May—I just want to remind members of that—with respect to New South Wales. Those on the committee at that time should have received that particular document. Just so you can see what it looks like as you consult your file, this is what it looked like.

With that, I want to ask our researcher, who has sent out a note on adoption disclosure laws in other jurisdictions: Alison, do you want to just comment on the document that you've passed out?

**Ms Alison Drummond:** I'll just comment on this very briefly. The subcommittee asked for some information on laws in other jurisdictions. I've very briefly described and attached the legislation from New South Wales and from New Zealand. I've also attached a very recent article from Maclean's on things that are going on

in Canada. And I made some phone calls and got information up to date for last Thursday or Friday on where proposed changes are at in other jurisdictions. Nothing's really at the stage of a bill that's been passed, so I haven't attached anything, although if people are interested in those Alberta private members' bills or the British Columbia report, I should be receiving that this week. I already have the Alberta private members' bills, but as you'll see from the memo, they didn't really go anywhere.

**The Chair:** That's fine, then, and members can get that if they wish. Just one final note. In our hearings we have allotted 15 minutes to each of the witnesses. This was in order to accommodate as many people as possible. If I could just ask members, as we get into questions tomorrow and next week, if you would also be mindful of that time limitation.

With that, there being no—sorry.

**Mr Hope:** The material that Ms O'Neill was asking for earlier, and I don't know if she made it in a—she was looking for some information. Is that going to be brought forward?

**The Chair:** Was this with respect to the freedom of information commission?

**Mr Hope:** Yes, with the commissioner's opinion on this legislation, whether it be coming through them or—where is that opinion coming from, I guess my concern would be.

**The Chair:** Okay. If I recall, the question was asked, Ms Belford, of you. You'd had some discussion with the commissioner and the question was, would this legislation be shown to the commissioner during this week?

**Ms Belford:** We had talked to the commissioner very early, when we were still developing options, but we have not talked to him lately. I will make an attempt to get him to review this. I don't know if we can do it in the time lines. I'll try.

**The Chair:** Okay. Perhaps you could let the clerk know if that can happen, and depending on that, we can discuss that, Mr Hope, if you wanted, at a future session.

**Mr Hope:** It was Mrs O'Neill's request from the commissioner. I was just following up to find out exactly where it's coming from.

**Interjection:** Randy's just being helpful.

**Mr Hope:** Just being helpful.

**The Chair:** Fine. Mr Jackson.

**Mr Jackson:** I suspect we'll have some technical backup support from both ministries to carry us through that period of time?

**The Chair:** Yes.

**Mr Jackson:** Fine. That should be sufficient as a linkage.

**The Chair:** With that, the committee stands adjourned until 3:30 tomorrow afternoon.

*The committee adjourned at 1756.*







## CONTENTS

Monday 28 November 1994

**Adoption Disclosure Statute Law Amendment Act, 1994, Bill 158, Mr Martin /**

**Loi de 1994 modifiant des lois en ce qui concerne la divulgation de renseignements**

**sur les adoptions, projet de loi 158, M. Martin . . . . . S-2567**

### STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair /Vice-Président:** Eddy, Ron (Brant-Haldimand L)

**\*Carter, Jenny** (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

**\*Gigantes, Evelyn,** (Ottawa Centre ND)

**\*Jamison, Norm** (Norfolk ND)

**\*Martin, Tony** (Sault Ste Marie ND)

**\*McGuinty, Dalton** (Ottawa South/-Sud L)

O'Connor, Larry (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Rizzo, Tony (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Duignan, Noel (Halton North/-Nord ND) for Mr O'Connor

Hope, Randy R. (Chatham-Kent ND) for Mr Rizzo

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

#### **Also taking part / Autres participants et participantes:**

Ministry of Community and Social Services:

Belford, Joan, policy analyst, children's services branch

LeClerc, Bob, planning coordinator, registration division

O'Brien, Pat, assistant adoption registrar, adoption disclosure register

Ministry of Consumer and Commercial Relations:

Hartman, Judi, manager, special projects, office of the registrar general

Sills, Nancy, legal counsel

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Drummond, Alison, research officer, Legislative Research Service

CANON  
X12  
-577

S-81



S-81

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 29 November 1994

# Journal des débats (Hansard)

Mardi 29 novembre 1994

Standing committee on  
social development



Comité permanent des  
affaires sociales

Adoption Disclosure Statute Law  
Amendment Act, 1994

Loi de 1994 modifiant des lois  
en ce qui concerne la divulgation  
de renseignements sur les adoptions

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

*1944–1994*

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 29 November 1994

Mardi 29 novembre 1994

*The committee met at 1534 in room 151.*ADOPTION DISCLOSURE STATUTE LAW  
AMENDMENT ACT, 1994LOI DE 1994 MODIFIANT DES LOIS  
EN CE QUI CONCERNE LA DIVULGATION  
DE RENSEIGNEMENTS SUR LES ADOPTIONS

Consideration of Bill 158, An Act to amend the Vital Statistics Act and the Child and Family Services Act in respect of Adoption Disclosure / Projet de loi 158, Loi modifiant la Loi sur les services à l'enfance et à la famille en ce qui concerne la divulgation de renseignements sur les adoptions.

**The Vice-Chair (Mr Ron Eddy):** Good afternoon, ladies and gentlemen. Welcome to the standing committee on social development, now holding hearings on Bill 158, An Act to amend the Vital Statistics Act and the Child and Family Services Act in Respect of Adoption Disclosure.

We'll proceed with the hearings now. Before having the first presenter, how do you wish to deal with the matter of questions? It's realized that times for the presentations are quite short, so one suggestion is to limit to one question per caucus and then, if it appears we have more time, we can do a second question.

**Mrs Margaret Marland (Mississauga South):** What I would suggest is that because they are 15-minute intervals, it would be up to the deputations if they chose to leave more time or are able to.

**The Vice-Chair:** Yes, I'll ask that.

**Mrs Marland:** But if they use up the whole time, then we couldn't allow any questions. I think we just have to play it by ear, and if it works out that we can all have a minute each, fine.

**The Vice-Chair:** Anyone else wish to speak?

**Mr Larry O'Connor (Durham-York):** I would suggest that we follow rotation through that process as well, just to keep some sort of order to that.

**The Vice-Chair:** Yes, I would think that. All right, we will proceed then.

MAUREEN FLANAGAN

**The Vice-Chair:** The first deputant is Maureen Flanagan. Please have a seat and introduce yourself and proceed with your presentation. As noted, if there is time within the 15-minute allocation, we will have a question or more. Please proceed.

**Ms Maureen Flanagan:** My name is Maureen Flanagan. One of the things, as I went through the process of finding out how to testify here, was that I was asked if

I'd be handing in a presentation so you could read it beforehand. I decided I didn't want to do that, specifically because I want to tell you how this has personally affected my life. I am not part of an organization. I have been on several different registries, but I am not here on behalf of anybody except individuals.

I have been on the adoption disclosure registry since 1989. When I was put on it, the first thing that happened—I sent everything in. I sort of found out through word of mouth because there really wasn't anything to tell me where to go to find information about it. They told me there wasn't a match. That alone took about eight months.

After that, I put in a request for a search. I assumed that would take—oh, I don't know, a few months. Little did I know. I am still waiting for them to commence a search, and it's been five years. I find that to be a little cruel, not just because of the emotional side of it for me, the fact that I have to wait and wait, but also because, in the normal course of my life, I move around and I go places. Right now, I've just been trying to tell them that my address changed six months ago. I keep trying to phone and they don't even answer the phone any more at that place.

You guys are going to hear about the bureaucratic disasters. I know you've received a technical briefing on a lot of those, but in terms of how it impacts people, having to sit there and phone and phone and hope to God that nobody's contacted them in the meantime is rather cruel.

There's also the reality that, as far as my medical background is concerned, it affects me deeply. I don't have a terrible disease right now, as far as I know. I don't have any extreme problem. I'm not waiting for a transplant, but I do have a condition called endometriosis, and that means that I am at a very high risk for ovarian cancer, which they now know is inherited. In fact, there is a worldwide registry operating out of Buffalo called the Gilda Radner registry. I can't go to that registry and check for family history and see if anybody has died from ovarian cancer and if they're related to me, so I can check up on my risk level, because I don't have a clue if anybody has had that.

The non-identifying information that's provided for people doesn't really tell you anything because it stops at the moment I was born. As of 1968, I know the basics of my family medical history, bits and pieces, but I don't know anything that can really help me. They don't have accurate descriptions because grandparents, aunts, uncles, parents, all of those people wouldn't have been participat-

ing in this when my mother gave me up for adoption. They didn't even know she was over at this home for unwed mothers, so she couldn't exactly phone them up and say, "What precisely was it that you had?" at the time.

I can't even find out my risk level for a lot of inherited diseases. In a world where DNA and genetics mean a lot, I'm sort of lost.

1540

I've also got another problem. I had an operation in 1986 for a knee, not that big a deal, but they turned around and gave me Valium, not realizing what they were doing at the time. I had a massive drug reaction and I almost ended up in a coma. It turned out, after I got my non-identifying information, that my mother was given a pill—this is the only description—to relax and control her muscles the entire time she was pregnant with me. At that time, in 1968, women were given Valium, Quaaludes and several other different types of anti-depressants and depressants just as a matter of course. Nobody thought about what would happen when a pregnant woman received these drugs.

I had a massive drug reaction and I could have ended up seriously ill. I can't even find out right now because the only thing in my birth record is some vague, foggy description. I don't even know what to do right now when a doctor prescribes me a drug. I take a really big risk, because I don't want to end up like that again.

A lot of what the current bill will do might help this, but then again it might not, because I'm not going to be able to get my total file; I'm only going to be able to get the birth record. This is one of my biggest concerns with this.

Most of you probably haven't tried to participate in a search. If you had, you'd know how hard it is. There's no town to start from. I can't go into provincial tax records and look for things. I have to sit there and go to each and every city and look through Bell phone books or *Might* directories from 1955 or so on, trying to find some reference.

I have my last name. My birth name was Pauline Lynda Leonard; it's on my adoption order. Unfortunately, without a town to start from, I have no hope of sitting there and finding—unless of course one of you would like to help me travel across the province and search in every library and township.

I realize that Bill 158 is considered a compromise. Understand, I'm very grateful that you're willing to give us anything at all, but realize as well that it is just the beginning. From my personal perspective, I'm not going to stop. I am not going to let Bill 158 stop me if it doesn't pass or if it does. I'm going to keep going and I'm going to find all of my information. If necessary, I will break the law.

The reason I say that is because this isn't about what the Legislature thinks is right or what it is politically brave enough to do. This is about what I deserve as a human being. This is about my right to self-determination. This is about my health and my life.

I am scared to go out and have a child. What if I

passed on some disease? What if I'm at high risk for something and I don't know? Every day, I live wondering what it would be like to see somebody who looks like me or to see somebody who is related to me. I've even wondered once in a while when I've been on a date and thought to myself, "What if this person is my second cousin and I don't know?"

Some day there will be open records everywhere. It doesn't matter effectively what happens to this bill, because it's going to pass sooner or later in some form somewhere. I would prefer that it happens now and I would prefer that it happens to be this government right here, because I'm tired of waiting. But understand that as you sit here and debate about this, this is a little bit bigger than this Legislature and it's a lot more important than a few petty political concerns.

I ask all of you to please try to work together and try to allow this bill to pass before you close sitting on December 8. Thank you.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Ms Flanagan, I know that you've likely looked at the bill. How do you feel about it? Do you feel there are things that could still be added to it or changed? Would you like to say a little bit about that or the amendments, if you've seen them?

**Ms Flanagan:** Yes. One of the things that concerns me is that I feel that the fine should not apply when someone's life or health is at stake. Right now there are approximately 500 people sitting on the registry list whose lives are in danger and needing transplants. There are actually far more who need the information. These people would not be acting out of some cruel concern or some violation of someone else's rights; they'd be concerned about their life. In that aspect, I think that fine should not apply to them.

Also, the \$5,000 fine should probably not apply when the father is listed as unknown on the birth record. The only way to contact the other half of the family is to contact the mother. Even if she never wants to speak to you again, just finding out who the unknown father is—many of them didn't bother to write it down or circumstances didn't permit them to write down who it was. That would be a very key amendment.

We have to make sure that the total file is available, every scrap of information, because just having a name isn't enough. It must be the entire file.

**Mrs Marland:** I'm wondering, would it work if there was some kind of agency that the mother gave the information to? In your case, it's the health record that you're most interested in, apparently, from what you've said, which I may add you've expressed extremely well here this afternoon. If the mother is one of these mothers who's saying, "No contact," if there was an intermediary person or agency that could take that information so you would still get it, would that work?

**Ms Flanagan:** It might possibly if it were only the mother who would be concerned. There is the problem, though, where when you're tracking a genetic disease you need to know all of the relatives in the family tree. A doctor such as, for example, my doctor would have to have access to all of their medical records or their doctors

in order to know what precisely the risk was. The problem comes that you need to have each individual person's permission to contact their doctor and get their medical records. It becomes a nightmare when you're dealing with an agency which has a bureaucratic concern with keeping distance.

**Mrs Marland:** Keeping the privacy.

**Ms Flanagan:** Yes.

**Mrs Marland:** You said, "If necessary, I will break the law." What do you mean by that?

**Ms Flanagan:** What I mean is that I would go ahead and save up the \$5,000, if I had to, to pay the fine and, if necessary, I would defend my right to have this knowledge all the way to the Supreme Court of Canada, if I had to. Civil disobedience is not an unknown tradition in this country. I am not saying that I would run out and do this secretly, but in my view the entire concept of closed adoption records is unconstitutional. I would like to see what the Supreme Court would say and I would be very happy to be an example of that.

**Mr Randy R. Hope (Chatham-Kent):** The whole emphasis behind your presentation is dealing with the medical information because of the new diseases are currently in our society and the treatment that is out there. How do we implement a program so we can access most of that information for the future, so you're able to intake all that information at one point versus having to travel? I mean, your concern was also having to travel around the province and look at every phone book possible. How do we then put in that information to address the concerns that you're bringing forward today—and I know this will not correct your problem—to correct future problems that occur in similar situations to that you're facing today?

**Ms Flanagan:** For one thing, you could allow the registry access to provincial tax records. We have the ability to find people when we want them to pay income tax. I don't see why we can't find a way to find them when we want to access their medical records or talk with them.

It would also be good if, in terms of health in this province, we had registries for inheritable diseases such as the Gilda Radner Institute for Ovarian Cancer. That's a private registry where they're trying to trace the genetic history of that. But we don't have anything in Canada like that.

It's also the reality that when people travel, they travel across borders. People could be anywhere in the world right now, and the way to do this is to start warning people: "When you give up a child, understand that this is still a lifetime commitment. If you develop a disease in five years, phone us. We'll contact the agency, we'll contact the parents and let them know that you've developed epilepsy or something else that they should watch out for in their child."

Stop making them believe that somehow the moment they give up their child, their commitment ends, because the moment they conceived, that's when their commitment began.

**The Vice-Chair:** Thank you for your presentation. We appreciate your appearing.

1550

#### ADOPTION REFORM COALITION OF ONTARIO

**The Vice-Chair:** The next presentation will be made by the Adoption Reform Coalition of Ontario.

**Ms Patricia McCarron:** My name is Patricia McCarron. I'm the chairman of the Adoption Reform Coalition of Ontario.

**Mr Tom Vradenburg:** My name is Tom Vradenburg. I'm also with the Adoption Reform Coalition of Ontario. We're here today on behalf of ARCO. ARCO is a province-wide coalition of individual members of the adoption triangle, that is, adoptees, birth parents and adoptive parents. We advocate the right of access to identifying information by all adult members of the triangle.

We've worked with many people to write a brief, which you may have a copy of. It was submitted to the minister in May 1993. It includes what we believe is necessary for adoption law reform, and we've submitted a copy for your information.

Please be sure to understand that we heartily support the proposed amendment to legislation in Bill 158. It's a very important first step towards an adoption system that's based on honesty and openness. We'd like to propose certain enhancements to point this legislation further down the road, so we'll deal with the measures in Bill 158.

**Ms McCarron:** I will refer to the summary of our responses we presented to the standing committee. We submitted it last June and I believe you've just received a copy.

First of all, we definitely agree with giving identifying information to adult adoptees and we propose extending the same right to birth parents and adoptive parents of minor adoptees.

We agree with the establishment of the contact veto for birth parents and we propose extending the same right to adult adoptees and adoptive parents of minor adoptees.

We agree with the principle of sanctions for breaches of the contact veto, but we believe that this should be dealt with by using currently existing legal measures. We also agree with the need to eliminate mandatory counselling.

With regard to the access to birth information, as of April 1994, adoptees may receive a copy of their adoption order without their adoptive parents' written consent. Most adoption orders issued before 1970 only contain the child's birth name but not the birth parents' names. This proposed bill would provide adult adoptees with information taken from the statement of live birth. It will give the name and address of the birth mother at the time of birth, her birthdate, birthplace and similar information from the birth father, if it was given at the time.

ARCO heartily supports this amendment, but we would like to see it enhanced so that the principle, and I stress the principle, of providing identifying information to one member of the adoption triangle is extended to all three parties.

Our first proposal, therefore, is that the amended birth

certificate, the long form, be made available to birth parents. This would provide identifying information about the adoptee.

Also, we propose that the statement of live birth be made available to adoptive parents of minor adoptees. This would provide identifying information about the birth parents.

Our rationale is simple: to apply the principle of equal access to identifying information for all three parties involved.

I now refer to the amendment to provide for the contact veto. The contact veto is being proposed on behalf of the birth parents to enable them to state their wish for non-contact from the adoptee. We support the implementation of this contact veto registry.

Our second proposal is to extend this right to register the contact veto to the adult adoptees and the adoptive parents of minor adoptees who do not wish for contact from the birth parents. The person requesting a no-contact veto must give a reason in writing why contact is refused or allow the veto to be qualified by being limited to, say, six months a year, or to restricted contact, say, in the case of medical information. The rationale for this is that since we advocate the right to access identifying information by all three members, then we also advocate the right to register the contact veto by all three members of the adoption triangle.

Our third proposal is to delete the proposal for sanctions for violating the contact veto. Use existing legal measures such as no-trespassing notices, restraining orders and harassment laws. In other jurisdictions that allow contact vetoes, relatively few are registered and only a very small percentage of those is violated. We therefore expect a minimal number of offences. Our rationale is that the proposed sanctions have serious flaws. ARCO believes it is unfair to single out adoptees who violate a person's privacy. Experience in the other jurisdictions has shown that written reasons are respected in the overwhelming majority of cases. There is an excellent report from the New South Wales Law Reform Commission, and I have a quote in my brief.

The fourth objective, regarding the amendment to make counselling voluntary rather than mandatory, we also agree to. The client should determine his or need for counselling before and after a reunion takes place.

We would like to add the following three recommendations at this time.

If it is not possible to extend the right of access to identifying information to birth parents and adoptive parents, given your time constraints between now and December 8, would the standing committee consider adding an amendment which would allow for a later review of the regulations to expand the category of persons, ie, birth parents and adoptive parents who would be receiving information pertaining to themselves or their kin, and the category of information. If there is updated information given by the birth mother, medical or other, an updated address, would that also be made available to the adoptee? That's something to think about.

Secondly, we would ask that the government recognize

open adoption agreements that are entered into by birth and adoptive parents.

Finally, given the one-year waiting period between the enactment of the bill and the proclamation date, we ask that the bill be proclaimed as soon as possible without undue delay.

Thank you for letting us make our views known.

**Mr David Johnson (Don Mills):** I'd like to congratulate you for an excellent presentation on a topic that I'm just starting to learn about, so bear with me. One of the points, I think your second point, was that all three parties in the triangle should have a contact veto, I think is the way you phrased that. I just wondered, from your experience, what numbers you would expect might use that veto if such a veto were in place from all three parties.

**Ms McCarron:** All three parties? In that New South Wales Law Reform Commission—there was a study done very recently. My colleagues might be able to help me out later on. I can't reel them off, off the top of my head, but we're talking a handful; we're not talking dozens or 50 or hundreds of people who have violated this sanction. We're talking of very, very few people, first of all, who put in a contact veto and once it was put in someone actually violated that contact veto.

When there was a written reason from the birth mother saying, "Please do not contact me at this time; my family does not know," in 99.9% of the cases the veto was respected. I am a reunited adoptee myself. That's the first thing you do. You say: "I don't want to disrupt your life. I just want some information. Whatever we can come to as an arrangement is fine." You're not there to turn that person's life upside down. As an adoptee, that was my position and I would most certainly respect that.

In cases where the veto was violated, it was more of an intervention of, say, a social worker or it was simply, "Sorry, she doesn't want to talk to you." I've known several cases like that and that just makes you more angry and you want to contact them even more.

**Mr David Johnson:** I guess that's true of adoptees and adoptive parents as well, that there are a few cases. Of the points you've registered, and you registered half a dozen or so, which is most important to you?

**Ms McCarron:** The principle of equal access to the identifying information.

**Mr Vradenburg:** For all three members of the triangle.

**Mr David Johnson:** That was really your first point.

**Ms McCarron:** That's right. We heartily support this bill. We figure if people can accept this principle of giving identifying information, then to give it to you and not to you and not to you—I have a hard time seeing the difference there or the understanding behind that. I understand that you're not going to be able to amend the whole act between now and next week. This is why we've asked for this back door where the regulations could be revised perhaps later on to extend the people who would have access to the identifying information and the type of information that will be permitted to be given out.

**Mr David Johnson:** You heard the first deputation, I guess, very concerned about medical information. Is that the kind of information?

**Ms McCarron:** That's exactly the kind of information, but also birth moms have gone back to the social agencies and said: "Has she tried to contact me? Here is my address and here I am. If she ever comes, make sure you let her know." As it stands, they are not allowed to give out that information. So if you're going to give me my birth registration form and there's an address in the file, why not be allowed to give that to me as well?

**Ms Evelyn Gigantes (Ottawa Centre):** I didn't understand the last part of what you were saying. If I could just go back over that, what is not allowed when the birth mother goes back and says, "Here I am"? What were you speaking to there?

**Ms McCarron:** If the birth mother has gone back to the social agency to check up on her child, as it stands now, unless the child and the mother are on the registry, she cannot provide that information to the adoptee. If I go into the children's aid society in Ottawa and say, "I want my background information," they'll give me all that. But if I ask them, "Do you have any updated information from my birth mom? Has she been back in?" they can't tell me that. They can't give me any information from the point of my adoption.

1600

**Ms Gigantes:** But as I understood yesterday from what we called our technical briefing by staff involved through Community and Social Services, there is currently operating a health and safety provision which would make immediate matters of the transfer of health information available.

**Ms McCarron:** Perhaps my request wasn't medical or urgent enough, but I did not get any further information.

**Ms Gigantes:** I think it does have to be quite urgent.

**Ms McCarron:** I have an adopted sister who was just recently reunited with her birth mom through our own search. She had a sister on the registry and they were on the registry for 18 months before a match was actually found in the files. When we wrote in to ask the reasons why, there were problems in the system, but now I understand they've changed that a little bit so things are getting better. But I'm saying at the time that I did my search, that's the information I was—

**Ms Gigantes:** The process is extremely slow.

**Ms McCarron:** Yes.

**Ms Gigantes:** Could I go back to another item that you raised, which was your interest in supporting what I think you called open adoptions? Could you explain that?

**Ms McCarron:** Today, the way I understand it, if a birth mother wishes to relinquish her child to someone she knows—say she wants to meet with the adoptive parents—there is nothing in the legislation to recognize such an agreement. There's no legally binding agreement. The mother may choose the adoptive parents, but there's no legal enforcement to say that the adoptive parents have to keep that mother up to date or maintain regular contact.

I'm just saying that it's a fact of life today that there are these open adoptions, there are meetings, there are arrangements between birth parents and adoptive parents that are very open; they know each other. It doesn't mean they have Sunday dinner every week, but it means that there is this contact. All the information is disclosed. We haven't gone into this in as much detail, because it's something that has to be studied down the road. I'm just saying it is a fact of life today that the Child and Family Services Act will have to review or study at some point in the future.

**Ms Gigantes:** One of the things that strikes me, listening to your statements to us and also the first witness who came to us, is that traditionally in families there have been a lot of matters which may not necessarily have been shared among members of families where all the children are birth children. In fact, there may be medical histories which are not shared. So the onus that you're putting on the system of adoption is a higher test than we see applied in other areas of family life. That interests me a great deal.

I'm a strong supporter of opening up information flows as much as we can do in conscience. But I'm concerned, for example, with the testimony from our first witness which suggests that essentially, once a woman has conceived, her life is from then on beholden in terms of information she must provide. We don't live our lives that way in families with no adopted kids. We don't say to parents, "You have to tell children everything and you have to reveal all your private life and you have to say who your sexual partner was when this child was conceived." It may not have been the so-called father in the family. There are a lot of things about families we don't know and that we don't try and force.

So I'm very interested in trying to make sure that as we move towards a situation where I think a very important part of life for people is to understand who they are, where they came from and why they were given up as kids, principally—because I think that's a very painful thing. I know it's also painful for mothers who have given up children not to know what happened to them. Inasmuch as we can do that without setting up a regime where everybody feels eternally obliged to reveal all secrets, then I'm really prepared to do that. But when you ask us to say in principle that in future we should make it a three-way share, I don't think I'm prepared at this stage to do that, because women conceive children and bear children under circumstances that in some cases they don't want ever to have to talk about again.

**Ms McCarron:** Which is fine. That's what the contact veto is there for.

**Ms Gigantes:** But there is also a kind of attitude that well, you conceive a child—we just saw it in the first witness; I'll be perfectly blunt—your life's an open book and you're on the rack forever.

**Ms McCarron:** I probably wouldn't describe it the same way, but I guess what we're asking for is at least the choice or the right to have access to that information, and how we contact the person and how we deal with that information as an adult and how we deal with the relationship with that person is our right of choice, our

freedom of association with another adult. From what I understand, the right for the child to know takes precedence over the right of the birth mother's privacy.

**Ms Gigantes:** That's why this bill is before us. That's why I support it, but I must say that the notion that we agree in principle to changes in the future, I guess I'm not ready for that quite yet.

**The Vice-Chair:** Thank you very much for your presentation and answering the questions.

KATHERINE KIMBELL

**The Vice-Chair:** We're ready for the next presenter, Ms Kimbell. Please introduce yourself for Hansard and proceed with your presentation.

**Ms Katherine Kimbell:** My name is Katherine Kimbell. I'm an adoptive parent from Ottawa who strongly supports this bill and would like to see it passed, if possible. I'm grateful for the effort made in getting it this far.

I am here to speak for many people who stand to be affected by this bill who cannot speak for themselves. I met these people when I lived in Quebec and in Alberta and I heard stories of people from this place and that place who didn't know what to do. Only now that I'm back in Ontario do I wish I'd kept an account of these people. Many of them were affected by Ontario adoption law and they have not been consulted by the government. Well, it's pretty difficult. When it had its closed consultations in 1992 and 1993, these people weren't even informed about the changes being consulted.

I remembered the ones I have met and I remembered their problems, so I thought their feelings probably match those of their neighbours where they now live. I keep in close contact with major adoption support group leaders in six other provinces and a few other countries, so I thought I would contact these people and ask what they were feeling about adoption law reform, because the people in their communities and parts of their groups would include birth parents, adoptive parents and adoptees who are affected by the Ontario law. This would be an interesting test. It would be feedback to Ontario.

I contacted these major group leaders and they each have sent me back a letter that they wish to speak to the Ontario reform. There's no need to require you to look at all these, but for your information, I have copies of these letters. Without exception, they all applaud this first stage but would certainly like to see adoption reform for all adult parties equally, with a contact veto, of course.

These groups are, going from east to west, Parent Finders in Halifax—and by the way, Nova Scotia has just published its governmental report on the matter, with the minister's recommendation behind it with access for birth parents and adoptees and the contact veto.

1610

In Manitoba we have LINKS Post Legal Adoption Support Group Inc in Winnipeg.

In Saskatchewan we have the Triad Society for Truth in Adoption. Saskatchewan also is doing a study on the matter but its report is still pending.

In Alberta we have Open Adoption Records in Alberta,

in Ardrossan. Again, the Alberta study—public open consultation—supported access for all parties, 88% of the public. We have also Parent Finders in Edmonton. We have the Triad Society for Truth in Adoption of Canada in Calgary. That's the national office.

In British Columbia we have the Adoption Reform Coalition of Canada in Vancouver; we have the Forget-Me-Not Society in Langley; Parent Finders of British Columbia, Vancouver, whose chair is a major pioneer in adoption reform, Joan Vanstone.

Also from Vancouver we have here a letter—I would be glad to make copies if these would be wanted—from the legislative study committee chairperson, Margaret Lord, to the Minister of Social Services in British Columbia stating that they would like access to information extended to all parties. This is a very recent letter. In addition, we have people from Quebec, two authors, who support this position.

I'm going to then tell you some of the findings we received from out of Ontario. One is on the right to privacy against the right to information and the contradiction or the conflict that appears there. These people agree, and it's been well stated in the Nova Scotia report, that if there is a contradiction between two individuals or parties, the right to information supersedes or outweighs the right to privacy.

On another position, we have observed that there was never any legislative basis for privacy of the birth mothers, and we have found that there are certain excellent precedents from other jurisdictions on the use of contact vetoes very successfully.

There are two studies that are published on this matter. One is from New South Wales, this law reform commission study. It's the most up-to-date and I would certainly like to recommend that the committee would examine this material at some future date. Also, I personally hope the Ontario government will continue to show strong leadership in law reform on this crucial matter. We'll stop there.

**The Vice-Chair:** Questions? Mrs Marland.

**Mrs Marland:** Actually, I think it's the government's turn.

**The Vice-Chair:** I had Ms Gigantes as the last speaker.

**Mrs Marland:** Oh. I thought we were going in rotation, that's all. We started the last time, but I'm happy to go. It was the government that asked to go in rotation. We started the last time but the Liberals didn't get on.

The last two deputations have both referred to this New South Wales Law Reform Commission report. Is that the only report that's available, and do we know how many numbers of families or individuals were involved in that report?

**Ms Kimbell:** A great number. All the members on the committee in June were sent a copy of this report. We had permission from the government of New South Wales to copy it for you. I'm not sure; I think you did not receive one, Mrs Marland.

**Mrs Marland:** I wasn't on the committee, no.

**Ms Kimbell:** They requested submissions from the population before they did the law reform in 1990. They received about 722. After the law reform was completed giving access to adoptees and birth parents, with the contact veto, they requested more submissions, saying, "Now are you happy with the law reforms?" They received well over 1,000 this time, more. Therefore, on the basis of that, they had proved that the law was satisfactory but that small fine-tuning was necessary, extending the access to even more parties.

**Mrs Marland:** The reason I am asking the question is that, as you know, I'm substituting on the committee today and when I hear this document being referred to, I'm wondering, is there no other similar Bible to the argument other than this particular study? There's nothing that's been done in the United States, for example, or anywhere else?

**Ms Kimbell:** In Canada, yes, another excellent study, not as comprehensive, was done by the government of Ontario, Professor Ralph Garber of the University of Toronto, in 1985. It was an excellent study and it came to two very interesting conclusions, principles: (1) The facts surrounding an individual's adoption belong to that person regardless of where they are safeguarded, and (2) on balance, the risks of revealing adoption facts to those to whom they refer have not been proven to be harmful.

**Mrs Marland:** So this all lends credence to the other conclusion you referred to, which was that the right to information outweighed the right to privacy.

**Ms Kimbell:** Yes.

**Mrs Marland:** To me, that's a fascinating statement to hear this afternoon, especially when our Freedom of Information and Protection of Privacy Act is really so new in this province. I'm just wondering if there has been any discussion around that part of it, because it's very educational for me to hear that.

**Ms Kimbell:** I can't say that it pertains to other things, but in adoption, when there has been such attention because of secrecy, this is the conclusion that Nova Scotia has arrived at, and it would appear from the letter going to the minister in British Columbia, Joy MacPhail, I think they are coming to this conclusion also.

**Mrs Marland:** How does this affect the contact veto?

**Ms Kimbell:** This means you have a right to access information, but to protect the person who still feels he wants privacy, he has the use of the contact veto, and if you give a reason why you place the contact veto, it's honoured almost all of the time. And the proof comes from New South Wales that for those who break the veto, there isn't a problem, and guess who breaks it often? It's the one who placed the veto. So it's not the problem that people fear it will be.

**Mrs O'Neill:** Katherine, you have spoken around Bill 158 rather than to it. Have you got any suggestions or have you examined the amendments? Is there anything you feel you'd like to say about the actual piece of legislation that's before us?

**Ms Kimbell:** We support it very strongly. We certainly would like to see it expanded, as was mentioned by the people who spoke before me. We would like to see it

expanded, but it may be too late now. If not now, then we would like to see those expansions considered at a future date, as soon as possible.

The fine-tuning amendments that we received in the last three or four days were too technical for us to absorb at this point. We felt they were relatively small points.

**The Vice-Chair:** If there are no other questions, thank you very much for your presentation.

MONICA BYRNE

**The Vice-Chair:** The next presenter is Ms Byrne. Please introduce yourself for Hansard and proceed with your presentation.

**Mrs Monica Byrne:** Good afternoon. My name is Monica Byrne and I'm a part of the adoption triad. I am a birth mother who gave birth to and relinquished a child in the province of Ontario in the mid-1960s. My private life, like your private lives, is very personal. I do not discuss such matters lightly. My closet is as deep as anyone else's. However, I felt this matter was important enough that I would come out of my closet and speak to you here if it were possible.

In 1986 I decided to try and find my daughter in order to pass on family information, medical information, history, and, deep down, from an inner need to find out how she was, who she was, whether she was hungry, whether she needed me, whether she was happy and whether she was even alive. This is a need that most birth parents feel very deeply. We don't make the decision lightly in the beginning, and it lives with us all our lives.

1620

When I went to the children's aid society in Ottawa for information, I assumed, as I had been assured in the 1960s, that should my daughter wish to contact me, or I her, there would be no problem. I was truly horrified to discover the truth: the six-to-eight-year waiting lists; the minimal background information; and my right only to place my name on a registry, passively waiting for her to come to me. What if she had moved, left the country, didn't know about the registry, were dead? I could never, ever know her or have contact with her or even know why. I was truly devastated. This is in 1986. I had waited 19 months for the background information on her adoptive family. I was somewhat reassured. The family seemed to be very nice, seemed to have all the attributes that I would have wished for my daughter. In the interim I had married her father and I had three other children.

Since then I have become a full-time volunteer with Parent Finders and a board member of the Adoption Council of Ontario, the Adoption Reform Coalition, the American Adoption Congress and all sorts of other organizations dedicated towards improving the situation for adoption in Ontario and generally. I have consequently over the years spoken to hundreds and hundreds—I can't count how many hundreds—of people in the adoption triad that I have spoken to and counselled and listened to and helped in trying to understand their issues and empathize with them and point them towards where they can receive help.

I found my daughter. I did it myself. There was no help from the agency other than the background informa-

tion. I happen to be a good detective. I had to grovel before the children's aid, and I mean grovel, begging for information, the smallest, tiniest bits. Was my daughter baptized? Was she in Canada? Was she in Ontario? Did she live in Ottawa? Was there any idea? There was no information other than what had been taken up to the time of her adoption.

I felt that information was rightly mine as her parent. I would have wanted the original registration of her birth to have been available to her. I assumed there would be a mechanism for this to take place. I never believed or thought that my name should be hidden. I have privacy but not secrecy. I have a right to be private. I don't always want my neighbours to know all my dirty washing, as you don't, but I genuinely felt she had a right to know who I was, who her father was and where we were in the world. I couldn't parent her at the time. It didn't mean I didn't exist or that she did not have a fundamental right to know her birth identity.

It's for these reasons that I support Bill 158 fully. In addition, I really believe that all members of the adoption triangle should have equal rights. I don't feel one is supreme over another. I truly believe adoptive parents of minor children should have those rights to access the birth mother's name and some information about her. But I went back to the children's aid on several occasions over the years to update my information, to tell them where we lived, how many children we had, to ask, did she need help? There is no mechanism for that to be passed on to her at any time without her coming forward herself, as it stands. Bill 158 will give her her birth name, my name in 1966. It will be a long and hard search for her to find me in 1994, living on a different street in a different part of town. Luckily, I'm still in Ottawa.

I feel the contact veto provisions would protect me should I wish not to be available. In the same way, I would like to have had access to her amended birth certificate in order that I too could have accessed her if it were necessary or if I felt the need. She too could have had the contact veto provision, in my estimation.

I really, truly request speedy proclamation of this bill. I feel it is so important. There are thousands of people involved. We're not talking a few people, the few of us who are lucky enough to speak to you today and next week. There is so little time left till December 8. It makes me very nervous. I have been on pins and needles all day and every day for months since we heard this might be happening.

I request that anyone filing a non-contact veto be obliged to give a reason. I think that's only fair. If an adoptee comes and gets the notice that there is a non-contact veto, it seems only common courtesy that that person should have to say why. There may be a personal family reason, and that's fine; just say it. It will satisfy the deep inner need in the adoptee to hear: "I have not told my husband." We know all the reasons people would not wish to be found. There are lots, but that's fine.

We hear, we read—I have read a lot on this, and I hear from other jurisdictions—that there is not a problem with this contact veto or with people abusing it. It is a very few people who abuse it. Generally speaking, if people

have a good reason why the birth mother or father does not wish to be contacted, they will honour that, if they have a reason. If they're just told, "She doesn't want to see you," then it inspires curiosity.

I do feel the contact veto should be time-limited. That is, she should either have to renew it after five years or three years or some period, because if she dies and there is a veto on that file, there may be other people in that family who would have wished that information.

I thank you very much for listening to me.

**Mr O'Connor:** I appreciate hearing another view and I'm sure we're going to hear a lot of very personal stories as we take a look at this piece of legislation. There has been limited discussion yesterday, during a technical briefing, about signing the non-disclosure paper and having the opportunity to repeal and invoke it again. What are your thoughts on that?

**Mrs Byrne:** I really don't think there are any problems once the birth mother has thought about it. Generally speaking, with the current atmosphere of openness; more and more, people hear reunion stories every day. They only have to turn on their TVs and watch Oprah and everybody's being reunited with everyone.

The birth mother who places a contact veto, it may be a knee-jerk reaction, and that's fine. She's just terrified right now. But generally speaking, as they get used to the idea—I have contacted birth mothers who have said, "No, I don't wish to meet the person right now." That's fine. She will sit back and think about it and switch on her TV and suddenly Shirley will make sense to her. She'll see a reunion and she'll say, "That could be me," and she will phone back, after six months. We have many examples of them phoning back after six months or a year and saying, "Can I change my mind?" So, yes, I think it should be possible to change your mind and you should be able to change it at least once or twice. People are human and circumstances in all our lives change drastically. What if the husband, the dread husband about whom she is so nervous, dies? The fear may be gone then that he find out about this child that she gave up years ago. No problem. She should be able to change her mind.

1630

**Mrs O'Neill:** Monica, you have presented very well and certainly worked us through Bill 158. That was helpful. You seem to be focusing on one particular section of the bill, and that is the non-contact veto, which I suggested yesterday too I do feel has to be examined by the freedom of information commissioner just to see what he thinks of it, and that hasn't been done yet. We've requested it in this committee.

The bill also, as you know, as it stands now, only permits one change of heart, so to speak. You're suggesting that more should happen, and certainly some members of the committee suggested that yesterday.

**Mrs Byrne:** That's a personal feeling, yes. There should be a limit, but it shouldn't be absolute. We've dealt too long with absolutes, you see. That's how I feel.

**Mrs O'Neill:** Okay. You also suggested that you feel a reason is extremely important.

**Mrs Byrne:** I do.

**Mrs O'Neill:** If there's no mandatory counselling, how do you feel that can happen? Many people do not want to give reasons for many things.

**Mrs Byrne:** It doesn't have to be a big reason; a form that is filled in, "Why do you not wish contact?" There will be some discussion with a social worker at some point when they're handing in the form. There will be an opportunity at some point and careful questioning, just saying, "Why don't you want to meet your daughter, Mrs Smith?"

**Mrs O'Neill:** I think that would likely be provided in that the option is there. I think that's enough for my questioning at the moment.

**Mr David Johnson:** One of the other topics that you hit upon was the information that should flow to all three parties. I just wondered if you could be more specific in terms of what information you think should be available to all three parties. We've talked about medical information, for example, here earlier today.

**Mrs Byrne:** I think the same provisions, that as the adoptee should have access to the original registration of live birth, so the birth mother should have access to the amended birth certificate with the name of the adoptee on it, and the adoptive parents of minor children should have the birth mother's name.

**Mr David Johnson:** So we're essentially talking about people's names, that the names should be shared all the way around.

**Mrs Byrne:** Yes, and hopefully if any parties have come to the agency after the fact of the birth, there is sometimes updated information. As I say, should my daughter receive her registration of live birth, it will give me 30 years ago; it won't give information about me now, which could save her a lot of time if she were looking for me.

**Mr David Johnson:** Let me ask you about the health information that was the topic a couple of presenters ago. In your view, how should adoptees be able to obtain the health information that was sought by the first deputant?

**Mrs Byrne:** That's a difficult question. I haven't really considered how that could be done. I think it depends on how they're approaching the birth mother. If she is dealing with an agency, she can update the file. I can't answer that question right off the bat.

**Mr David Johnson:** That's fair enough. I can't answer it either.

**Mrs Byrne:** It depends on whether she has been found, whether the adoptee has her name. They can always phone her up and ask her, if they have the name. If she has requested a non-contact, then I think questioning at the time would say: "Are there any medical situations in your family that the adopted person should be aware of? Have you thought of updating the file at least to that extent?" It would be, then, non-identifying information.

**Mr David Johnson:** So there might be a mechanism whereby a person may not wish contact and may register the veto but may be willing to somehow put information through.

**Mrs Byrne:** At the present time in Ontario, if the

government does a search for a birth mother and she refuses contact, she's usually asked some questions at the time, and generally the birth parents will furnish some information.

**Mr David Johnson:** Do you foresee perhaps a mechanism whereby adoptees could ask for contact but in the event that it was denied they could list perhaps a series of questions with regard to medical circumstances that might be answered?

**Mrs Byrne:** Yes, I think that would be a very useful part of the non-contact veto, sure.

**Mrs Marland:** So you agree with the intermediary agency aspect that I asked about, then.

**Mrs Byrne:** Yes, to some degree, without it being terribly intrusive. I think most parties to the adoption are not terribly keen on social service agencies—

**Mrs Marland:** Understandably.

**Mrs Byrne:** —or social workers, especially the birth parents. They have had rather unfortunate—in many cases; not all. I had a very good social worker. But I hear from many birth mothers that the last person they would like to hear from in the world is a social worker. They have unhappy memories.

**The Vice-Chair:** Thank you very much for your presentation and answering the questions.

**Ms Gigantes:** Could I ask one quick question before the witness leaves? You talked about the situation, and you used an example, "If my daughter were looking for me, all she would have from Bill 158 is a copy of the statement of birth, which gives me 30 years ago," you say, being much too harsh on yourself, by the looks of you, "but she wouldn't have me today." Then you went on to say, "If she wanted to contact me, it would save her a lot of time." But if she wanted to contact you and your name were on the registry, then that contact would be made relatively easily and relatively quickly.

**Mrs Byrne:** Yes, that's true, except given the slow, plodding speed of the registry.

**Ms Gigantes:** We heard from a previous witness and we heard yesterday from staff that in fact within a year, if there's an immediate match to be made, a match gets made. Is this not your experience?

**Mrs Byrne:** This is the optimum. However, I know from personal experience several cases in which matches have not been made. I've done the search for this person, they matched up and these people are still waiting to be informed that they have been matched in the registry. There are errors, clerical errors on the registry. They don't always match people. It's just as simple as that.

**Ms Gigantes:** I'm sure that's true.

**Mrs Byrne:** It's just bookkeeping.

**The Vice-Chair:** Mr Martin wishes to submit information, I believe, regarding the bill.

**Mr Tony Martin (Sault Ste Marie):** We have made contact, on request from Mrs O'Neill yesterday, with the freedom of information and privacy branch of Management Board of Cabinet. In instructions from the director of that branch, a Mr White to a Mr Heriges who gave us the information, it was indicated that they, at this point,

having looked at the legislation, really had no need to pursue the matter any further. They were comfortable that there was nothing here that raised any red flags for them.

The only privacy issue was whether or not the privacy of the birth parent was being violated by Bill 158, and that in fact is the purpose of the bill: to change the act so that, in law, that information could be given to an adult adoptee. Therefore, according to Mr Herriges, that decision is then a policy issue.

The draft bill defines the information covered in this bill as information relating to an adoption. Information relating to an adoption is exempt, as well, from the freedom of information and privacy act. Therefore, Mr Herriges feels that there is no technical issue here for him.

If we wanted to pursue it further, to the commissioner, that's always open to us to do if you felt that you would be more comfortable.

**Mrs O'Neill:** I just felt that it would be very helpful to have in writing from the freedom of information commissioner that the non-contact clause of this bill was in accordance with his understanding of the privacy rights of this province. I felt it would be better to get that before the bill was passed than to have it challenged afterwards.

**Mrs Marland:** Mr Martin, are you the parliamentary assistant?

**Mr Martin:** It's my bill.

**Mrs Marland:** I know it's a private bill.

**Mr Martin:** I'm not the parliamentary assistant to either of the ministries involved.

**Mrs Marland:** You're not the parliamentary assistant to any of those associated ministries?

**Mr Martin:** No.

**Mrs Marland:** Can I just ask—I noticed that the first reading was in May of this year—is the government supporting your bill?

**Ms Gigantes:** That's why we're here.

**Mr Martin:** That's why we're here. We wouldn't be here today if I wasn't getting—

**Mr O'Connor:** —support.

**Mrs Marland:** It's an amendment to existing statutes. If the government supports your bill, why didn't the government just make the amendments?

**The Vice-Chair:** I'm sorry. We should move on with the hearings. If we get into technical details—I think we should deal with them at the end of the meeting, if you don't mind. I recognize your questions. Mr Martin, do you wish to respond very briefly to that?

**Mr Martin:** No.

**Mrs Marland:** We could have avoided the time factor. If the government's in favour, it could have—

**Mr Martin:** It's a red herring that the Conservatives keep bringing up in front of this bill. It's a private member's bill that's moving forward nicely.

*Interjections.*

**The Vice-Chair:** Thank you for your presentation. Ms Gigantes, please.

**Mrs Marland:** Excuse me. On a point of privilege, Mr Chair: This is the first day I have sat on this bill—

**Mr Martin:** Perhaps you should have paid attention.

**Mrs Marland:** I beg your pardon?

**The Vice-Chair:** Please, one speaker. Mrs Marland has the floor at the present time. Proceed, Mrs Marland. Do you wish to proceed?

**Mrs Marland:** Not with that ignorant comment that was just thrown across the floor. No, thank you.

**The Vice-Chair:** We should move on with the hearings at this point.

**Ms Gigantes:** Just to the point about the protection of personal privacy, I think there may be a mistake here in the understanding of some members of the committee. The Freedom of Information and Protection of Privacy Act is not like the BNA Act. It's not a constitutional document. It is possible for a government policy to be directed specifically to deal with matters related to the protection of privacy or the release of information that may not exactly coincide with that legislation but where a similar kind of precaution is taken about the protection of privacy.

I think that's the nature of the comments we've had here from the commission, which is to explain that there has been a policy decision made, that the framing of the legislation takes into account the policy considerations that are of concern if one is going to create legislation which is consistent with having a bill that protects personal privacy. But it doesn't mean that it overrides any legislation the government brings forward.

**The Vice-Chair:** Thank you for the information.

**Mrs O'Neill:** Well, Mr Martin asked for my opinion, and I would like to give it at the end of this meeting on what further action I think I would like to have.

**The Vice-Chair:** We'll move on with the hearings.

1640

KARL HAAG

**The Vice-Chair:** The next presenter is Mr Haag. Please introduce yourself and make your presentation. You'll be allotted your full time for sure. Welcome to the committee.

**Mr Karl Haag:** My name is Karl Haag. I'm adopted, and I'm also looking for my children. They were adopted without my notice. I read the bill. In a very simple way, when I read this bill and I put it in plain English, it tells me, "I'll give you this, but you can't have it, and if you take it, I'll get you." So I can't support this kind of thing. I think we should have something more straightforward.

First of all, on adoption, I think the basic right of a person should be that they have the right to know their parents and their roots. This must be the basic right. I'm quite sure you all grew up in a family. You knew your parents. You took it for granted. You know your children now. You take it for granted. You wouldn't have it any other way.

**The Vice-Chair:** Not necessarily.

**Mr Haag:** But do we also have the same right, or are we just something that falls by the wayside? We must have the same right. I'd like to know my children too. I

think everybody should have the right to know, even the children.

I was at an adoption rally in North York, and there was a lady who spoke who had adopted a little boy. The little boy is now seven years old. She said that he knows he's adopted and he would like to talk to his parents. Why can't that child talk to his parents? You have this thing in there that people should be able to turn down the request to talk to their children. I don't think that should be. I think once you have a child, you have a responsibility. That goes with it from the time you gave birth. There is a bond between birth parents and children. The bond sometimes is only one way.

This kind of thing has terrible effects on people. I can talk for myself, because it had an effect on me so bad it almost killed me. So I think we should have the right to know our parents and we should have the right to know our children, exactly the same as you do. You take it for granted; you don't even question it. But for us there seems to be a different law, and I don't think that's right. I think we should have the same law and the same rights for everybody. We'd like to know our parents too and our heritage, just the same as you do. So I think there should be no question.

Also, this privacy law is another thing. When I look at the privacy law, it's used by people who try to hide something. If I have something to hide, what do I hide? Something that's not quite on the level. The privacy thing is extended to things that—I think it's ridiculous. I don't have anything to hide. I don't need the privacy law.

What I'd like to see is the files opened. Let's open the files and lay it on the table so that everybody has the right to see and know their children and the children know their parents, the same as you take for granted. Give us all the same right. Don't question all those things, and don't give people who don't want to see their children the right to deny it. I think they should have to meet at least once. Then they can lay their cards on the table. Sometimes you have to get the ball rolling to get things going. Once they meet, things will be different. Like this little boy, I think he should have a right.

Also the age limit, I think it's crazy. I found out about my parents when I was five years old. It wasn't the greatest deal. I didn't know the full impact. It took me a little while to figure it all out, and it didn't cause a great disturbance. So this little fellow, if he has to wait 11 years—in 11 years a lot of things can happen—he may never find his parents, and if it affects him the same as it has affected a lot of us, it would be sadistic to say that he can't do that. So I think he should have a right to know his parents. The same goes for me.

For instance, what interests me in your bill, it says, "birth parents as defined on the birth certificate." My name was not put down on the birth certificate. There was some kind of a game played. It's a very twisted story. I had to find out about the first-born in the lunchroom at work, and then the mother came back 10 years later and the whole thing started all over again. There was another child born. I had to find out 25 years after that child was born about that child, when I looked for the first one.

I would like to know my children just the same as anybody else. They're part of me, they're my soul, and I don't have a right to know. I went to the Catholic children's aid society, and I was told, "You weren't supposed to know." Obviously, they know that I'm the father. There are also people who were involved in this on the street, they also know I'm the father, and yet I don't have the right to know.

I would like to see the file opened. I'd like to see what's up. I'd like to know what happened to the kids. I also think that the kids have been told so many stories about me just to make sure that they wouldn't look for me, because then the whole thing would come out. I think somebody has to hide something because something would stand up as illegal. This is why they try to keep them away from me.

The kids have grown up now. The son would be now 36 years old, and the second one would be 26 years old. If I find them today, all I can hope for is that maybe we could be friends. They have grown up. They have also a tie to their adoptive parents, probably. I know what happened to me; the tie can be very strong. You stick to your adoptive parents also. I'm not trying to cause problems, but I would like to know the truth. I would like to know my kids, and I would like to know the truth about the whole thing. But I don't have that right. I ask myself, "What country do I live in that I don't have the right to know my own kids?" They're my family. That's all I have. They're my only family I have, and I don't have the right to know.

I would like to see the files opened. Just open the files and let everybody see it who is interested in it. I can't see that somebody would look at the files just simply because that's what they want to see. I think anybody who wants to see the files has something to do with it, so I think they should have a right to know, without the restrictions and "Maybe you can have that, but you can't have this, and if you do it, then I'll fine you" and all this. That's terrible. I mean, you wouldn't stand for it. Why should we? I think we should have the same right as you have. You know your parents, and you take it for granted. There are no questions asked. You wouldn't even have it any other way. You never give it a second thought, and the same with your own family, and yet you don't grant that right to us. I feel sometimes like a piece of toilet paper you use and you flush down the drain.

I have tried to find out more. I tried to find the birth certificates. I can't get hold of them. Then I applied to find out if there was a marriage certificate for the mother, because I know that she married again after, and I would like to find that. I applied a year ago, I paid the \$30 and I haven't heard yet. I have no rights. I can't find out.

It says there that you have to prove that you're the father. Now, how am I going to prove this unless I can find the kids and I can say, "Okay, let's have a blood test and we'll check it"? I'm sure the kids know it too, but there's so much said. I went up to the street where the mother used to live and I asked around there, and I went into a house there. The fellow looked at me. From his looks alone, I know he knows. I used to go there and I used to see this girl, and then he was involved from the

start. When I first met the girl, she was pushed and we bumped into each other and I was going to go after the guy because he pushed her and she said, "No, no, let him go," and all this kind of thing.

1650

Then she wanted a baby so bad and I tried to explain to her and I tried to reason to her. I was only here a year. I didn't have the means to support a family and I tried to tell her, "Why don't we wait a year?" She told me she was 17. I was 22. I said: "Give me two years and then we can think of it. We can't just simply have a family with no way of supporting it."

Every time I saw the girl this thing came up, and finally she was doing it in front of her parents. It was very embarrassing. Then one night she asked me to come over and she had a few friends over. I thought she had a little party, she wanted to introduce her friends, so I walked right into a trap. The friends were there, but the minute I walked in they took off out the back door. We were left alone and it started all over again.

But that night was a little different than the rest of the time. I learned she had a vile temper, and before I knew it she ripped the clothes right off me. I didn't know even what to think.

I saw her for about three weeks after that. That was long enough to find out that she was pregnant. Then one night I was over and she told me she wouldn't be seeing me any more. She was looking at a photograph; she was on the beach with another fellow somewhere else. So I asked her if this was her boyfriend. She said no, an ex-boyfriend.

Then I thought I had said something, I had done something that wasn't right, and I tried to talk to her and I tried to get it back on track. But every time I went to the house I couldn't get an answer. When I called there, her mother would say, "She's out with a girlfriend," or something, and I could never find her.

I went back for six months and at one point she opened the door and she looked like she was pregnant, but it didn't really fizz at the time because all I could think of was, "Why doesn't she talk to me?"

Then I had to find out at work. There was a lady living in the same area and one day we were sitting in the lunch room and she looked at me quite sternly and she said, "You don't care about your kid too well." Then she told me she had seen the mother with a little boy—blond, curly hair and brown eyes, the spitting image of me. I couldn't lie about this.

I went back to her house. I tried to find out. I tried to talk to her. I wanted to see if she wanted to get married. I couldn't get an answer.

**Ms Gigantes:** Mr Chair, on a point of order: We need to decide how much time to have the witness make a presentation.

**Mr David Johnson:** I think, Mr Chairman, we decided that beforehand. He has up to 15 minutes, if he chooses.

**The Vice-Chair:** Yes. There may not be time for questions. That's the point.

**Mr David Johnson:** There may not be time. If he chooses to use the full time, that's his prerogative.

**The Vice-Chair:** Yes. Please proceed, sir.

**Mr Haag:** What I'm asking is, do I have the right to know my family? Do I have the right? I don't like the idea where you have down "the father as identified on the birth certificate," because it's not always the father. I went to the register and I was told there that this happens fairly often. I also talked to a lady who used to work in the Catholic children's aid society and she told me there were quite a few court cases about this kind of thing. So I'm asking, in a case like this, what rights do I have? Do I have the right too? I mean, I'm not looking for somebody else's kids. I'm just looking for my own.

**The Vice-Chair:** Yes, we understand that. Well, the hearings are to hear points that you would like to make about this bill. If you have suggested changes, and I know you have many things in your presentation as to making changes in disclosure—

**Mr Haag:** I'd like to have the files opened completely, with no bits and buts to it. Just open it. Do away with the register. The register doesn't serve a purpose. It's so backlogged and it doesn't tell anything. Some of the kids don't even know they're adopted and people don't know where to look. So let's just open the files and let everybody see the files if they want to see the files, and make sure that people can talk to each other.

If a parent does not want to talk, make sure they have to talk at least once, so that the kids will find out. Each side can lay their thing on the table and it will relieve the tension. Once you get them talking, this may lead to more. But I think we should do much more to bring people together who belong together.

**The Vice-Chair:** Thank you. We understand your viewpoint on this important matter. Are there any questions at this time? If not, thank you very much for your presentation. We have heard you.

PARENT FINDERS—NATIONAL CAPITAL REGION, INC

**The Vice-Chair:** The next presenter will be a representative of Parent Finders from Ottawa. Please introduce yourself and proceed with your presentation.

**Mrs Judith Kizell Brans:** Good afternoon. My name is Judith Kizell Brans. For the past eight years I have been the executive director of Parent Finders—National Capital Region, Inc. I am here as a representative of my organization to strongly support Bill 158. I would like to begin by giving the committee a brief description of the work that Parent Finders—National Capital Region has been involved with over the past 18 years.

Our organization began in 1978 with the purpose of providing assistance, information, support, referral, resources and a private registry to adults who were searching for information and/or reunion with family separated by adoption in Ontario. What began as a small group of concerned adult adoptees, birth parents and adoptive parents meeting in someone's living room has now grown to an organization receiving approximately 2,000-plus phone calls a year, at least 600 written requests for assistance a year and once-a-month public meetings of approximately 65 to 100 concerned persons.

The executive donates its time, and funding comes from memberships and donations, though in the past 18 years the city of Ottawa has granted us some small grants.

The membership that I am representing here before the committee includes adult adoptees whose birth or adoption took place in Ontario, birth parents who relinquished a child or had a child adopted in Ontario, birth family members and adoptive parents who are searching for Ontario birth family members of their minor and/or their adult adopted children. Also included in our membership are individuals residing in the national capital region who may be searching in other provinces.

Our membership is not only from Ontario and the national capital region but from other provinces and territories of Canada, from the United States, from Britain, from Finland, from New Zealand, from Germany and from Australia. All of our overseas memberships are people who are searching and/or who have relinquished in the province of Ontario. This bill will affect their lives; it is not just those of us who are living in the province of Ontario.

Parent Finders—National Capital Region has on file close to 9,000 birth names, birth dates and birth places. We also have access to approximately 32,000 birth name, birth date and birthplace records which are held by Parent Finders' national headquarters in Vancouver. Parent Finders—National Capital Region is also able to check with another 20,000-plus records which are in the possession of a private searcher who is sympathetic to our membership's searches.

Our membership is very excited about the prospect of the passing into legislation of Bill 158. I would be pleased to be able to go back to my membership in December and explain that the Ontario government has made Bill 158 legislation, allowing them access to an extract of their live birth registration. That would be an absolutely phenomenal Christmas present to give to thousands upon thousands of people.

Parent Finders—National Capital Region is delighted with Bill 158 as a first step, but would have liked the proposed legislation to have included the enhancements of equal access to identifying information for birth parents, birth grandparents and siblings of the adoptee and to adoptive parents of minors.

We also support the no-contact veto. However, again, we would have preferred one with a time limit and to have it expanded to include adult adoptees, allowing them the same rights as a birth parent.

Please recognize that Parent Finders—National Capital Region is supportive of Bill 158 as the first step in eliminating discrimination under the law within the Ontario adoption legislation. Personally, as a birth mother, I too am strongly supportive of Bill 158 as a first step in law reform.

1700

**Mr David Johnson:** I thank you for your presentation. It has certainly been helpful. I just wondered, given the involvement that you've had in thousands of cases, what are the primary reasons? Is it an emotional reason? Is it for medical reasons? How would you break down

people's reasons for attempting to find their birth parents?

**Mrs Kizell Brans:** Knowledge about oneself, finding out what your name was at birth, exactly where you were born, finding out that your birth date actually belongs to you, your birth history; medical reasons are very strong; just to know where you came from, something that people who are not adopted take for granted. It's all mixed in. Basically what a lot of people are looking for is information about themselves, about where they came from. That's basically what they want. They want everything.

**Mr David Johnson:** That's what I guess I would call an emotional reason, which I'm sure is very strong. The reason I ask the question is because, through some of the deputations, we've been talking about medical reasons, and I just wondered how important that was.

**Mrs Kizell Brans:** Medical information is vital for the wellbeing of any person, whether you're adopted or not. To know what is in your background is exceptionally important. To be denied that information not only has an impact on your life, but imagine going in for major surgery and going to your doctor who asks you about your medical history and you have to say, "I don't know, I don't know, I don't know."

**Mr David Johnson:** Given that, which I can't disagree with, I wonder if your organization then had any suggestions as to how that medical information should flow from the birth parents to the adopted child. I'm thinking of the case of the veto, for example. If the veto is invoked, how should that information flow back?

**Mrs Kizell Brans:** I think that's been addressed previously, but I would agree that if you're going to have a contact veto, perhaps part of the obligation of a birth parent or whoever is putting on the contact veto is that they supply some medical information to whoever is gathering the information for the government. I understand that was addressed, but I haven't had an opportunity to look at the information that was faxed yesterday. I understand that the children's aid, the adoption disclosure registry, whoever is handling the contact veto, should also be able to gather information and pass it on if someone is not choosing a direct contact.

**Mr Hope:** I have just basically two questions dealing with your presentation on page 4, number 7 and number 8 of the remarks in the brief you submitted. It's Parent Finders.

**Mrs O'Neill:** That's the wrong brief.

**Mr Hope:** I thought maybe I'd be able to get it on the record now. You're not dealing with their presentation then?

**Mrs Kizell Brans:** No.

**The Vice-Chair:** I believe this presentation is for next week. It's Parent Finders Ontario and this is Parent Finders Ottawa, so it's a different presentation. Go ahead, though.

**Mr Hope:** I'm going to ask a question out of the presentation, if that is all right with you. In the presentation of your overall association, if a minor adoptee becomes a crown ward, the ministry is required to notify the adoptee's birth parents of his or her status. What is

being required is for the ministry to notify the adoptee's birth parents of the status of the child, and I was just curious why. When somebody puts a child up for adoption and it becomes a crown ward, why would you want to know, if you've given that right away?

**Mrs Kizell Brans:** My question would be, why not? The parent is still the parent of that child. We do not understand what the circumstances were of why the child went into crown wardship. It could have been because the parent was ill, it could have been that at that particular point in time they were financially unable to manage the child. A parent would want to know where their child is, I would think. You have to look at, why would a parent not want to know what happened to a child they gave birth to?

**Mr Hope:** My question would be: What protection would be there for the child in an abusive situation? Being warded to the crown, being in an abusive situation, why would you notify a parent of that abusive situation?

**Mrs Kizell Brans:** Since it is not my brief—

**Mr Hope:** Okay, but it's coming from a provincial, and usually when you're provincial, everyone sings from the same hymn book. I'm well familiar with provincial organizations and their branches, and they come from the same hymn book most of the time. I'll wait till next week to ask the next presentation. I just wondered why it was here. Why would it be a day in advance for us to read?

**Mrs Kizell Brans:** Maybe I should clarify that. The name Parent Finders is held by a woman in Vancouver, whose name is Joan Vanstone. She started the organization. If you want to start an organization, you must get approval to use the Parent Finder name, and though we share a common database and we share common principles, each organization works just a little bit differently. We are all in support of equal access, open records, but each organization may be presenting it just slightly differently.

**The Vice-Chair:** Thank you for the clarification. That's helpful.

**Mrs O'Neill:** Judith, you said you hadn't had time to read it, but it will be the Ministry of Community and Social Services that will be putting the non-contact registry on to its own database. We've had, as others have mentioned, quite a bit on medical information today. You're suggesting that would be the spot where you would suggest medical information also be recorded by MCSS.

**Mrs Kizell Brans:** I would suggest it would be one of the spots; perhaps the local children's aid or the children's aid that managed the adoption. Most birth mothers usually return to the children's aid where the adoption took place. If you're dealing with a private adoption, you're probably having to go through the registry because the lawyer or the licensee—what I would probably suggest is that somewhere down the line, in an overview of the legislation, perhaps when they were looking at adoption, what they look at is the gathering of information and finding out how they can make sure that the information is transferred. So that's down the road in looking at adoption as a whole and how licensees and

agencies gather their information.

But the ministry, the children's aid, right off the top of my head; as to others, I haven't had the opportunity to delve into it and do a little investigation so I can't comment further than those two suggestions.

**Mrs O'Neill:** Is your opinion that the non-contact veto is the situation in which the medical information would and should be recorded by some government agency?

**Mrs Kizell Brans:** I think so. Even though there is a non-contact, I think the majority of people would be willing to supply and should be able to volunteer some of the more basic information like heart, diabetes, stroke, any genetic disorders that might be helpful. I think that should be part of the no-contact veto platform just in order to ensure the medical safety and health of private individuals.

**Mr Dalton McGuinty (Ottawa South):** I think one of the obligations that we have here on this committee and in health, on every committee in fact, is to consider some of the downsides of any piece of legislation, and there's rarely a piece of legislation that's introduced that doesn't have at least some downside. Now the downside that I see here that I think we've got to consider, and it doesn't necessarily overwhelm the legislation at the end of the day, to my way of thinking, is the right to privacy of the birth parents.

Now there's going to be a no-contact provision found within Bill 158, which will give some assurance to birth parents that in fact they won't be contacted if they don't want to be contacted. One of the things that concerns me, though, is this need to know your history, as you so eloquently described. It can be so primitive, so powerful, so consuming. I think it could also be overwhelming. I wasn't here for the first presenter but I understand she said that she would ignore a no-contact order.

You've had, I understand, fairly extensive experience in these matters, but can you give us some idea of what incidence there would be of violations of no-contact orders? We have to anticipate these things so we go into this with our eyes open.

1710

**Mrs Kizell Brans:** You are always going to have a percentage of any population which is going to violate any legislation or act. It's very difficult to get inside someone's head to say why this particular person would break a no-contact veto. If they have the medical information, if they have a name, if they have a valid reason for no contact at that particular point in time, the assumption being made by the majority of people is that that would be sufficient at that particular point in time. Even with my training as a counsellor, I wouldn't want to step out and say why someone would break it. Why does someone break any other legislation? We won't know. Some people's desire to know is so powerful—

**Mr McGuinty:** I want to just take you up on that point, but this is different from other legislation. We're dealing with a very, and understandably so, emotional issue, and it can drive people to do things they may not otherwise be inclined to do.

**Mrs Kizell Brans:** Again you're asking me to comment on why someone other than myself would break a contact veto. Why would they break it? Because of their desire to know the circumstances of their birth, to be able to be connected to someone else, because they are by themselves; for any number of reasons. If we went around this table, I'm sure each one of us could come up with a reason why someone would break the contact veto.

There is no doubt, I think, in anyone's mind that somewhere along the line someone's going to break the no-contact veto. Someone's going to do it. Then we may have an answer to the question.

You're right, it is emotional, and when people get emotional, highly emotional, sometimes they do irrational things. But you also have in place in the legislation the fine and other legislation covering harassment, stalking laws, that would protect the person who is being contacted through a no-contact.

Again, I wouldn't want to say specifically, "These are the reasons why someone would break it." They're emotional. When people are highly emotional, they sometimes do irrational acts. They may regret it later, but they've done it. And we're dealing with adults. We're not dealing with children here. We are dealing with the adult community.

I'm sure that's not an adequate answer for you, but it's the best I can do at this particular point in time.

**Mr McGuinty:** Thank you.

**The Vice-Chair:** Thank you for your presentation. We were pleased to have you.

JEANNINE LAUGHER

**The Vice-Chair:** The next presentation will be by Ms Laughler. Welcome to the committee. Please have a seat and introduce yourself for Hansard and proceed with your presentation.

**Mrs Jeannine Laughler:** Mr Eddy and members of the committee, my name is Jeannine Laughler, and I'm an adoptive parent who is in full support of Bill 158. This bill would amend the Vital Statistics Act to give adult adopted persons access to all information contained in their original statement of birth, without requiring anyone else's consent. But it's also important, in my opinion, for adoptive parents to be provided with the same information to share with their adopted child.

I understand that this bill will also establish a no-contact register to be administered by the registrar general. I disagree, however, with section 57.1, which states that an adoptee who violates a birth parent's wish not to be contacted can be fined up to \$5,000. This proposal, in my opinion, is unfair to adoptees in that it singles them out with harsher legislation than for that of the general population with similar convictions. We have laws which govern such matters as stalking or harassment. It's hardly necessary to impose special legislation to deal with this issue. The already existing laws should suffice in dealing with whatever problems, if any, should arise from such a situation.

As an adoptive parent, I had to collude with a dishonest system in order to adopt a child. The rights of adoptive and birth parents who sought to change information

to protect their own interests robbed their children of their rights, two very precious rights: their identity and their right to be dealt with honestly by the adults involved with the adoption. It's time that we stopped protecting the rights of adoptive and birth parents at the expense of children. They are not chattel; they are human beings with the same rights as the rest of the population.

Why then did those with whom we entrusted our children agree to go along with such dishonesty? It's time to correct this injustice and to do it without further delay. Give these adoptees their birthright to know who they are.

**Mr David Johnson:** I just wondered, from the presentation, do you really believe in the veto clause, in the no-contact veto?

**Mrs Laughler:** Yes. At this point in time, I think it's necessary in order for this legislation to go through. Perhaps in years to come we could become more open-minded about it, but I think the right of birth parents to a no-contact at this point in time, given the fact that we are asking for the change in the Vital Statistics Act, is necessary, that we have this in place so this legislation will go through.

**Mr David Johnson:** The reason I ask is because your primary concern seems to be with stalking or harassment.

**Mrs Laughler:** Well, I'm concerned in that I feel we are singling out a segment of the population in a way we don't single out the rest of the community in similar situations. In other words, if a spouse were to harass or stalk or if a partner were to do the same thing, it seems to me there are laws already in place for people who act in a way that is not a lawful way to act, not a right way to act, and I don't believe that this should be part of the legislation in the sense that, to me, it seems harsher than for everyone else.

**Mr David Johnson:** Let me put words in your mouth, and I'm sure I'll be wrong, because whenever I do this I'm invariably wrong, but it appears to me as if you feel that adopted people should have almost the right to contact their birth parents. They should not be able to stalk or harass, but they should have the right to contact their birth parents.

**Mrs Laughler:** I think, given the information that they have, it's up to them to make that decision. I think that certainly, yes, they should have the right to attempt to contact their birth parent. However, it's up to the birth parent whether they're open to that or not.

**Mr David Johnson:** Now, when you talk about a dishonest system, you say that as an adoptive parent, you've had to collude with a dishonest system in order to adopt a child. Could you be more specific?

**Mrs Laughler:** I think every child has a right to the name of their birth parent, where they were born; this is very basic information that everyone should have. As an adoptive parent, to pretend that a child has your surname and that whatever happened before no longer exists is very dishonest. I firmly believe that. In fact, in my opinion, we regressed somewhere along the way in that when we adopted our children, they did have a surname. Now they're a number.

**Mr David Johnson:** It's the philosophy of the system that you're saying is dishonest then.

**Mrs Laugher:** That's right, and as I said, up until—well, in 1970, when we adopted, certainly we had the surname of our children, and that's no longer possible.

**Ms Gigantes:** Ms Laugher, thank you for your submission to us. I've had a long interest in this subject because I'm an adopting parent of a daughter who's now 27, and I've always believed, as many of the witnesses here today have said to us, that it is an important element of life for an adopted child to be able to get as much information as possible about the natural parent. Often it's only one parent who's identified.

When we last had a discussion of this nature in this Legislature, around 1987, as I recollect, the emphasis then by people who didn't want to see change and see the improvements we got in the 1987 legislation was on the need to protect the family of the adopting parents. Clearly the emphasis has changed now, and clearly when we see concerns raised around changes to the existing situation, what we're talking about is providing some element of protection to the natural mother. That's the discussion we've had here today, in any case.

I must say I have a great deal of sympathy for that, because I think we are making an assumption in some of the discussion we've heard here today that women conceive and have children and give them up for adoption and may later in life not wish to have contact somehow as a matter of convenience or as a matter of stealth or as a matter of not wanting to disturb an existing relationship.

But I think many women conceive and give birth in situations where the parentage of the child is of enormous distress to them. We know that a lot of women who are victims of incest bear children, that many of them become psychiatrically disturbed because of their family situation growing up.

1720

I think we may be going too far at this stage to say to ourselves soothingly, "Well, it's just a matter of convenience," or "It's a matter of lifestyle," or "The immediate family of the natural parent doesn't know." There may be real grounds why a natural mother would find it intensely distressing to have to revisit the way in which that child was brought on to Earth.

**Mrs Laugher:** I agree with what you're saying, but I think you're stating a case for a very small segment of the population.

**Ms Gigantes:** That's true. Well, we don't know, I suppose.

**Mrs Laugher:** Does one put aside the rights of the children involved—all the children involved—in order to protect the rights of a small segment of the population? I don't think so.

**Ms Gigantes:** Well, do we know how small a segment it is? I don't know that we do.

**Mrs Laugher:** Perhaps not, but I think the situation you described—of course I'm making an assumption, but I think it's a correct one—the extreme example you gave I think would be a minority. If you're talking about the

number of birth parents who would not be open to this, I can't speak to that, I wouldn't have the statistics, but if you're asking me to maybe speculate as to the example you've given, I think that would be a minority, a very small percentage.

**Ms Gigantes:** I would expect that you're right and that in fact most of the women involved in giving up children for adoption are not bearing children through incest, but I don't know we can say it's an insignificant number. I must say, when it gets right down to it, I have some real hesitations about saying in principle I'm going to let go of the part of the legislation now or in the future that would say to such a natural mother: "No, you can always be open to contact. You don't have a right to say no contact. You don't have a right to say you don't want to revisit."

**Mrs Laugher:** That's right. And as I said before to Mr Johnson, I'm not speaking to that piece of the legislation. If that is what it would take to get this legislation through, then I would support that, because it is a beginning.

I also feel, as I pointed out before, that it seems to me, though, that fining children such an exorbitant amount of money puts the children in a special category, and that does concern me. Not the fact that if they were to harass or stalk a parent I would go along with that, no, of course not, but that they would be dealt with differently, I do object to that.

**The Vice-Chair:** Thank you for your presentation and answering the questions. We appreciate it.

DEBBIE JACKSON

**The Vice-Chair:** The next presentation will be by Ms Jackson, please. Welcome to the committee. Please introduce yourself and proceed with your presentation.

**Mrs Debbie Jackson:** Good afternoon, members of the social development committee. My name is Debbie Jackson. I'm here to speak to you today in regard to Bill 158 and its impact from my perspective.

I was born in Toronto, August 17, 1956. I was adopted at two and a half months of age by wonderful adoptive parents. I had a very good home. All three children in my family, who were all adopted, were each told at an early age about our adoption.

The opening of the now-sealed adoption records in Ontario is of extreme significance to people like myself who, through no fault of their own, find themselves in a genetic and cultural no man's land. I have no idea if my heritage is English, Scottish, Irish, French, German etc. All I have been told is that my birth mother was Canadian—nothing on her heritage, background, where her family's roots originated, whether she came from a rural or an urban background, what part of Canada she lived in. I don't have any idea of my birth mother's or birth father's medical history or background. My two teenage children have no idea of what one half of their nationality is.

As adoptees, we are the only group of people who are denied access to our original birth records, information everyone else takes for granted. When I tell people that, as an adoptee, I'm not entitled to my original birth

certificate, they're incredulous. They shake their heads in disbelief. The secrecy involved in past and present current adoption practices is an insult to our intelligence. This secrecy has caused far more harm than it ever did good.

The implementation of Bill 158 would enable adoptees such as myself to a less embarrassing and less time-consuming search. Many adoptees are able to find their birth parents without having access to this information, but it is a far more difficult process. At the present time, in spite of having been registered with the ADR for close to three years, I'm still facing a seven-year wait for the ADR to do my search. In seven years, my birth parents could very well be deceased. My birth mother would be 58 years old now.

In my case, my birth name was Patricia Maxwell Smith. I'm reasonably sure my birth mother's surname was Smith, but I do not know what her first name was. All I know about her is that she was 20 years of age when I was born, she was a Canadian, she was Anglican and she was employed by a US airline as a stewardess. Can you imagine trying to find somebody 38 years later with so little information?

I've spent a great deal of time and money in my search for my roots and I've repeatedly encountered brick walls and barriers due to the secrecy involved to protect the confidentiality of all parties involved. Many misconceptions about adoption exist. Many people don't realize the confidentiality and secrecy surrounding society's attitude towards adoption in the past has done nothing but cause a lot of grief and pain for the adoptee, the birth parents and the adoptive parents. It's now proven that openness is essential in the process and that the reunion process is both beneficial and healing for both the birth parents and the adoptee.

Another point people don't realize is that the adoptee was the only party in the adoption triangle—which consists of the adoptee, the birth parent and the adoptive parents—who was not given any choice in the matter. The adoptee was the chattel or the goods in the adoption process. Where the birth mother had the option of making choices and the prospective adoptive parents were given choices, the adoptee had no say whatsoever in the matter. The adoptee was handed over blissfully innocent and unaware of what crucial life-altering changes were about to take place in his or her life.

Even in adulthood, the adoptee is still being deprived of his or her basic rights, the right to know what most human beings take for granted: to know the person who brought you into this world; to know who is the person you are genetically, historically, physically and emotionally connected to; to have some idea of family history; to have an idea of our past. It's been said that in order to know where you're going, you must have an idea of your past, something that we, as adoptees, have been denied. We're still being kept in the dark even as adult, taxpaying Canadian citizens.

Adoptees often find it hard to envision that we were actually born to a real person. It's almost as if we were dropped out of the sky. We find it very difficult to have a real sense of identity. The not knowing the truth is

more difficult than even finding out something negative.

The time is long overdue for the province of Ontario to open our adoption records. A change in current adoption laws and the unsealing of Ontario's adoption records are necessary to stop treating adoptees as second-class citizens.

I'd like to add that I am in support of Bill 158. I feel that the no-contact clause is a small price to pay for having access to our original birth records.

Any questions?

**Mr O'Connor:** I appreciate you coming before the committee. I know we've talked over the telephone about this issue. There are always some concerns when we deal with something of this nature, and the no-contact clause I guess you're willing to accept. We heard from our very first presenter, who said that even with something like that, regardless of that, she felt strongly that she was going to go out and seek out her mother, her birth parents.

1730

I just wondered if you'd want to comment on that. I know for us it's hard to understand because we're not in that situation and don't feel that emotional tug that is there, and it's real. When we had some discussion in the Legislature, one of my colleagues, in response to some of the discussion, started shouting that this is the end of the adoption process, that people will never look to making that decision of putting up a child for adoption. I just wondered if you might want to comment on that as well.

**Mrs Jackson:** Unfortunately, I wasn't here earlier to hear the other speaker. I don't know, all I can say really is that I feel you have to respect the person's privacy. If they choose to exercise the no-contact option, then I feel that's something we have to respect, and I most certainly would. But as Judith was just saying earlier, there may be the odd person who does this, but I think most reasonable people would respect that.

**Mr O'Connor:** If there were a form to be filled out, and I'm not sure exactly how this would be envisioned in the no-contact veto provision here—you talked about the lack of your genetic and family history. I guess that's part of what draws on you and tugs at your heart.

**Mrs Jackson:** Oh, yes.

**Mr O'Connor:** I wondered if you would see some of that being something that would be discussed with the birth parent when she signed the veto that might ease some of that tugging that must be tremendous to live with.

**Mrs Jackson:** Personally, what I would like to see in this case is that if birth parents do decide to exercise the no-contact clause, they should be required to submit a detailed medical background. I think that would only be fair, really. At least it would give us that, because right now, at the present time, I have no medical background whatsoever. In fact, I'm fighting with the hospital that I was born in. They are telling me they have no record that I was born there and yet I was there for the first two and a half months of my life because I was quite premature. I was two pounds, three ounces when I was born. I was 12 weeks premature, so I definitely was there. Medical

history is a very important thing to me. I have two teenaged children too who would like to know. If ever something were to happen to one of them, it would certainly come in handy, not to mention the annoyance when you've visiting your doctor and you have a routine physical or something and he says: "Well, come on. You must know something." You have to keep on saying, "I'm sorry, doctor, I don't know."

**The Vice-Chair:** Any other questions at this time? If not, thank you for your presentation. We appreciate it.

The next presenter is Mr Rioux. Not present? If not, we have one additional presentation to be made in camera. However, we will proceed and have Mrs O'Neill speak to the point that she wished to previously, before going in camera for the last presentation.

**Mrs O'Neill:** If I may ask Mr Martin what he was presenting to us today, Mr Chairman, was that a verbal report and a verbal opinion?

**Mr Martin:** That was a verbal report, a verbal opinion.

**Mrs O'Neill:** Okay. The reason I brought this forward is that over the weekend there were two people who came to me and were quite concerned about Bill 158. They were concerned about the no-contact veto and I had nothing to assure them that anybody other than the legislative counsel to this committee had ever examined it. In this province we have such a body, and I feel, as preliminary to this and to allay fears or state basic rights or to verify what this bill really does, the no-contact clause would be passed by the commissioner for his opinion—his opinion only. The government may or may not take the opinion, but at least we would have it.

As I say, I'm very aware of the protections and exemptions around adoption information. They're there and they're exempt. This may be that simple an answer: Because this is an adoption bill it is fine. But we're starting a whole new registry. I am very impressed with the work that's been done on both sides, particularly by Consumer and Commercial Relations, because this is a whole new area for them. The way they presented yesterday, I have utter confidence that they've thought of lots of things. But I would like to take advantage of every, what should I say, resource we have in this province to examine the bill as closely as possible. So if the government members are willing to submit it for an opinion to the actual commissioner and if he would be willing to send something in writing, it would certainly make everybody's job easier.

**The Vice-Chair:** Mr Martin, we'll leave the request with you at this time?

**Mr Martin:** Sure. It was particularly the no-contact clause.

**Mrs O'Neill:** That's the only thing I feel really needs examination. We're getting different opinions today that we should open it maybe more than once. He may even want to comment. We've worked with him before. He sometimes has opinions that he's not asked for. That's fine with me on this.

**Mr McGuinty:** On a different issue, Mr Chair, I was wondering if either research or Mr Martin might have

some figures as to the incidence of breaches of no-contact provisions of a similar nature in other jurisdictions. I think that would be of some assistance to us.

**Mr Martin:** Legislative research may have some.

**Ms Alison Drummond:** The New South Wales Law Reform Commission that one of the witnesses referred to, and that was supplied to members of the committee, says in its executive summary on page VIII—I'll read the passage: "Compliance with the contact veto system is very high. Although there were rumours or suggestions of breaches, a careful examination of the evidence revealed only one incident that appeared to be breach of a veto." I'll see if I can find any further information, but I had seen that.

**Mr McGuinty:** I'm just wondering, one incident out of how many? It doesn't say?

**Ms Drummond:** It's not clear from that. I can see if it's clear elsewhere.

**The Vice-Chair:** We'll have a further report on that and a response later.

**Mr David Johnson:** Since we're talking about the no-contact, I have a few questions that perhaps could be answered. Maybe they've already been answered, since I've only been on this committee today.

As I understand it, there would have to be an offence and a conviction before the \$5,000 fine would set in. I'm not a lawyer, so maybe this is self-evident to all the lawyers in this room: What would constitute an offence, to start with? In other words, what constitutes a contact? Is that defined? These are rhetorical questions perhaps. If they've already been answered, fine. You can answer them now or you can answer them in your subsequent report, which I gather is coming.

Would they have to go up, knock on the door and say, "Hello, I'm your adopted child," or do you just watch the person from afar, or do you have to make written contact or any contact whatsoever? Is that defined, I guess, is one set of questions. Another set may be, who would lay the charge? Would it have to be the person who was contacted? Would it be the local authorities who would have to lay the charge? How would that work?

Maybe the third set of questions gets into speculation. I assume this would have to go to court for a conviction to be laid, so a judge would have to say that yes, a contact has been made. I'm just speculating on how a judge would deal with something like that. I guess it would get down to speculating on what a judge or a court would consider to be a contact and how that would work, precisely. I'm just kind of curious to have those sorts of questions answered, to see what sort of process would be involved that a person would go through.

**The Vice-Chair:** You're adding several matters to the point that Ms O'Neill was making, and it's taking up further time. The questions are registered.

But I had an indication from Ms Belford, who is the policy analyst for children's services branch, who wanted to comment a few minutes ago. Would you care to comment now, and would it be in response to any of Mr Johnson's inquiries as well?

**Ms Joan Belford:** I won't respond to Mr Johnson's

inquiries directly, although we have some information on some of those.

**The Vice-Chair:** Perhaps later, now that those are noted.

**Ms Belford:** We could do that.

**The Vice-Chair:** Please proceed.

**Ms Belford:** I want to correct a statement I made yesterday. Yesterday, when the freedom of information issue came up, I said that in the early stages of looking at this legislation we had asked the commissioner to look at this legislation. In fact, it was the director of the

freedom of information and privacy branch of Management Board of Cabinet I had asked to look at it, and not the commissioner. I alluded to the wrong office yesterday, so I wanted to correct that for the record.

**The Vice-Chair:** You are allowed to correct your own record, so thank you for bringing that forward.

All right. The questions from Mr Johnson are noted.

If it's in order now, the committee will meet in closed session to hear the last presenter. The committee will conclude following that.

*The committee continued in closed session at 1741.*





## CONTENTS

Tuesday 29 November 1994

<b>Adoption Disclosure Statute Law Amendment Act, 1994, Bill 158, <i>Mr Martin</i> /</b>	
<b>Loi de 1994 modifiant des lois en ce qui concerne la divulgation de renseignements</b>	
<b>sur les adoptions, projet de loi 158, <i>M. Martin</i></b> . . . . .	S-2585
Maureen Flanagan . . . . .	S-2585
Adoption Reform Coalition of Ontario . . . . .	S-2587
Patricia McCarron, chair	
Tom Vradenburg, public relations representative	
Katherine Kimbell . . . . .	S-2590
Monica Byrne . . . . .	S-2591
Karl Haag . . . . .	S-2594
Parent Finders—National Capital Region, Inc . . . . .	S-2596
Judith Kizell Brans, executive director	
Jeannine Laughner . . . . .	S-2599
Debbie Jackson . . . . .	S-2601

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

\*Gigantes, Evelyn, (Ottawa Centre ND)

\*Jamison, Norm (Norfolk ND)

\*Martin, Tony (Sault Ste Marie ND)

\*McGuinty, Dalton (Ottawa South/-Sud L)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Rizzo, Tony (Oakwood ND)

Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

**Substitutions present / Membres remplaçants présents:**

Hope, Randy R. (Chatham-Kent ND) for Mr Rizzo

Johnson, David (Don Mills PC) for Mrs Cunningham

Marland, Margaret (Mississauga South/-Sud PC) for Mr Jim Wilson

**Also taking part / Autres participants et participantes:**

Belford, Joan, policy analyst, children's services branch, Ministry of Community and Social Services

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Drummond, Alison, research officer, Legislative Research Service



S-82

S-82

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

## Official Report of Debates (Hansard)

Monday 5 December 1994

## Journal des débats (Hansard)

Lundi 5 décembre 1994

### Standing committee on social development

### Comité permanent des affaires sociales



### Adoption Disclosure Statute Law Amendment Act, 1994

### Loi de 1994 modifiant des lois en ce qui concerne la divulgation de renseignements sur les adoptions

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

**1944–1994**

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 5 December 1994

Lundi 5 décembre 1994

*The committee met at 1534 in room 151.*ADOPTION DISCLOSURE STATUTE LAW  
AMENDMENT ACT, 1994LOI DE 1994 MODIFIANT DES LOIS  
EN CE QUI CONCERNE LA DIVULGATION  
DE RENSEIGNEMENTS SUR LES ADOPTIONS

Consideration of Bill 158, An Act to amend the Vital Statistics Act and the Child and Family Services Act in respect of Adoption Disclosure / Projet de loi 158, Loi modifiant la Loi sur les statistiques de l'état civil et la Loi sur les services à l'enfance et à la famille en ce qui concerne la divulgation de renseignements sur les adoptions.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen. The standing committee on social development is now in session and we are reviewing Bill 158, An Act to amend the Vital Statistics Act and the Child and Family Services Act in respect of Adoption Disclosure.

Just before calling the first witness for this afternoon, I would just note with members of the committee, because we have tried to include as many as possible, there will be one question per presenter in order to ensure that we can hear from everybody and get through the agenda today.

## FAMILIES IN ADOPTION

**The Chair:** So with that, I would call on our first presenter this afternoon, representing Families in Adoption. Welcome to the committee. If you would be good enough just to identify yourself for members of the—

**Mr Lloyd LeBoeuf:** I assume I can sit here.

**The Chair:** Please. Could you identify yourself for members of the committee and for Hansard and then please go ahead.

**Mr LeBoeuf:** My name is Lloyd LeBoeuf. I'm representing Families in Adoption.

First, I'd like to thank the committee for the opportunity to address and I'd also like to particularly thank Mr Tony Martin for his introduction of this bill as a private member's bill.

As I said, I'm part of a group called Families in Adoption, which is basically a support group that collects and shares information with people who have or would like to adopt children.

My wife and I adopted a baby at birth about five years ago. It was an open adoption. We met the birth parents, her parents, the social worker, and we had a chance to discuss most aspects of adoption with all the parties involved. We found it very useful. It was a very emo-

tional experience, but it was the best way to proceed that we found, in an open fashion. For anyone considering adoption, I'd strongly recommend that process, as opposed to a closed adoption where the parties don't share information and don't have an opportunity to meet with one another.

This bill, as I understand it, would allow adopted children who haven't the information, to know where they were born, to find out who their biological parents are. We feel as a group, and we have discussed this, that this really is a fundamental right that adopted children should have and enjoy. Just having your biological surname, something as fundamental as that, that everyone takes for granted, now will be available to people who haven't had that opportunity or information in the past. I think that a lot of adopted children will take advantage of this proposal, this registry. Some may not feel the need to know; others certainly will.

As to the bill itself, we felt that the rights of privacy of the birth parents must be considered and acknowledged. We felt that noting on the registry that they won't want to be contacted was appropriate as well. They should have this opportunity to make that information known to any prospective adopted children who are looking to contact their biological parents.

We also felt, however, that the wishes of the child must be paramount, that they should have the absolute right to identify their biological parents, for any number of reasons, so that they could establish what they may feel is their original identity. It may be as simple as just satisfying a curiosity as to where they came from and who they were or who they are. They should have this right absolutely, maybe, if nothing else, so they can get on with their lives and satisfy that part of their lives. As I understand it, this bill allows for that right and we really support that and appreciate the fact that it was introduced that way.

The problem we had as a group in discussing this was with the potential to criminalize the activity of looking for your biological parents inasmuch as the birth parents have the right to request no contact and there is a penalty provision if the adopted child proceeds even though they have been forewarned that the biological parents wish no contact. We had a problem with the fact that there is a penalty in place for that.

We recognize that the bill is trying to balance the interests of all affected parties—the birth parents, the adopted child—but the fact that a criminal activity may take place if they proceeded after they were warned we didn't feel was warranted. We felt that this aspect of the

bill should be reviewed. We didn't have an answer to that problem, but we felt that it's an issue that should be revisited, that should be reviewed.

**1540**

Personally, I think it taints the intent of the bill. I think it's a little overkill. I think it's misplaced. There are other ways to deal with unwanted contact. There are anti-stalking laws, there are restraining orders. I think the very small minority of people who may abuse this information would probably act independent of any penalty anyway, so why provide for this overkill penalty to people who may have such an emotional need to satisfy that they would contact their biological parents against the biological parents' wishes?

That's the only negative part of this bill that we saw, that we felt existed. I appreciate the fact that this committee is addressing this concern. I think it's very important.

I'd like to thank the committee for the time and, again, Tony Martin for introducing this and all of you for carrying it forward.

**The Chair:** Thank you very much for your presentation. Ms O'Neill?

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I'm sorry, I don't have any questions. I think the presentation was very clear. I guess I could ask you to say a little bit more about your attitude towards the non-contact.

You definitely had a very different experience. I'm very aware of your kind of experience and no doubt it's the most preferable if all parties can be involved from the very moment of birth and even before. There are definitely concerns, as this bill is being debated, about the non-contact register and certainly the penalty that's attached, and I think that confusion around that is mounting. Do you see another way? Do you see a way of keeping the register as it is now and just encouraging people to register if they want contact? Would you see that as a more positive approach than the approach of having to register if you don't want contact?

**Mr LeBoeuf:** I'm not sure I have an answer. I understand what you're saying. I think all adopted children should have an opportunity to find out who their birth parents are, and I think this bill addresses that.

**Mrs O'Neill:** Right.

**Mr LeBoeuf:** I think we should also consider the rights of the birth parents. Perhaps in a situation 20 years ago a child was given up for adoption, the birth mother has married and she has a family of her own. The last thing she needs is the introduction of a family member that she has forgotten about to disrupt her life in the face of any number of problems that may or may not exist presently.

We didn't have an answer for that, and that's why my suggestion that perhaps we should relook at the penalty provisions of this bill, because there are no easy answers. I don't know if there should be a penalty provision. I don't know if you can create this bill and pass it in legislation without a penalty provision. I don't know. But to criminalize something that fundamentally drives most of us—that is, where do we come from, who are we, who were our parents? I'm not adopted, but I can well apprec-

iate those questions—I think is misplaced.

**Mrs O'Neill:** Okay. Thank you for your presentation. You are the first one who's really been as explicit as that on that item.

**The Chair:** Thank you very much for coming before the committee this afternoon.

#### CANADIAN ADOPTION REUNION REGISTER. ONTARIO CHAPTER

**The Chair:** If I could then call on the representatives from the Canadian Adoption Reunion Register, Ontario chapter, and I note for committee members that Mr David Stubbs, who is to follow the Ontario chapter, has indicated that he would, I believe this is correct, forgo some of his time if there are a few more questions for Ms Kramer. I believe it is Holly Kramer?

**Ms Holly Kramer:** Yes, that's correct.

**The Chair:** Welcome to the committee. Would you be just good enough to identify yourself for Hansard and make sure we have the name of the organization correct.

**Ms Kramer:** Good afternoon. I'm very glad to be here today. My name is Holly Kramer and I'm here on behalf of the membership of the Canadian Adoption Reunion Register. This is a private, not-for-profit registry which was established in 1974. As the umbrella group for Canadian search and support groups, CARR represents more Ontario adoptees than any other organization.

This has been the International Year of the Family, as well as the 20th anniversary of the law reform movement in Ontario, but we haven't had any celebrations as we head into our third decade of advocacy work.

I am an adoptee and through my own efforts I was fortunate enough to be able to find my birth mother in 1979. We both consider our reunion a miracle and a blessing and it has enriched our lives and the lives of my parents and my daughter.

I think it's important to remember that the first step towards changing punitive adoption laws was made right here in Ontario over 15 years ago via a private member's bill. This resulted in the enactment of Canada's first governmental disclosure registry. I don't know how many of you may recall that, as I do, but it showed very good leadership on the part of the Ontario government, and that's the kind of leadership we are looking for today.

A conservative estimate is that one in four Ontarians are affected by adoption. Over time, the volunteer sector and the private sector have facilitated at least twice as many reunions as has the official helper, and we've done it twice as effectively. To my mind, this makes us the experts. As you heard the other day, adopted persons are apprehensive about what we perceive as the possibility of a second rejection. The decision to search is not made lightly and we're very careful, exercising great discretion and respect for the privacy of our birth parents when we do a search.

Over the years we've developed a non-intrusive method for initiating contact with sensitivity, and as you'll hear from the Parent Finders representatives in a few minutes, recently we've been working with ministry staff to ensure that those who require assistance will continue to benefit from our wide experience.

Self-search, like adoption and like reunion, is a process. To take responsibility for a part of your life over which you've never had any control before is a positive step in personal growth and development. Self-determination is integral to what it means to be an adult in our society. After more than 16 years spent working with and for the benefit of the adopted, I think the word which best describes our goal is "autonomy."

I must say I find it intolerable when, as has happened here several times, we are referred to as adopted children. We were adopted and, like you, we were once children. Being adopted is a lifelong condition, but despite the good offices of the social work profession, which never anticipated it, we have grown up.

Most people can't quite comprehend why we're so adamant about having our right of access to personal information addressed in law. Maybe we're not always very good at articulating why this is so important to us, but suffice it to say that what matters here isn't whether we win you over by trying to make you understand what it is to be adopted; what matters is that you be able to distinguish between needs and rights. Human rights exist sui generis and by definition cannot be balanced against needs.

Last week the concept of necessary losses came up at this table. The adopted are well acquainted with loss. Social intolerance towards out-of-wedlock pregnancy and birth and towards marital infertility have cost us dearly. We have paid with our identities, our heritage and our reality to erase the stigma once attached to so-called illegitimacy and to personify the as-if-born-to myth.

We teach our children, as most of us were taught, that deception is wrong. Yet we've been forced to subjugate our right in order to fit a monolithic model of what is family. We will probably never know what the real cost of the shame and denial inherent in sealed records has been to our society.

Substituting fiction for fact has the effect of, as it's been aptly described, suspending us in a state of perpetual genetic bewilderment. Cut off from our ancestry, our clear demands for access to our personal truths have been dissected and discussed by those who will never know what it is to be adopted.

1550

Sealed records discriminate against us on the basis of circumstances of birth through deprivation of a right which all other Ontarians take for granted. I'm incredulous that in 1994 in this province we should be called upon to prove or justify such a fundamental human right.

We understand the social strictures into which we were born. We know about the prevailing social climate of years gone by, and we also know that restriction and control around disclosure of adoption information is a product of this century, not a universal social phenomenon. The question isn't whether we'll take no for an answer in the form of a contact notice; rather, the question is from whom we should be expected to accept no.

We strive to know the truth, and if no is part of reality, we'll accept it, as adults everywhere accept life's disappointments. What we cannot accept, however, as adults

who happen to have been adopted, is bureaucratic, uniform denial of our right to have our own real birth certificates.

On behalf of the membership of CARR and the wider adoption community, you should know that we are tired of consultations. We're fed up with studies, we're sick of empty promises and we're unimpressed with pacifying measures and sorry excuses. We wholeheartedly support the proposals in Bill 158.

Having said all this, I'd also like you to know that I've spent my entire adult life pursuing the rights of adoptive persons, and I appreciate having had this opportunity to present our views in support of redress for, as Dr Garber put it almost 10 years ago, the wrongs imposed by previous legislation.

**The Chair:** Thank you very much. As I noted at the outset, we will have a little bit more time for questions. We'll begin with Mr Jackson.

**Mr Cameron Jackson (Burlington South):** Thank you very much, Holly, for a very clear and concise and long-overdue presentation. I want to welcome you here especially because I know you've certainly kept me apprised of a lot of issues around adoption reform.

At the outset, I have a couple of questions. First of all, you have seen the so-called housekeeping amendments that were circulated a week ago. Are you comfortable with those? Have you any specific concerns around some of that wording?

**Ms Kramer:** Not in particular. I have looked at the amendments and, to my mind, they are housekeeping amendments. We don't really care very much how you people accomplish this; that's your job. We just want our birth certificates.

**Mr Jackson:** Okay. The other new piece of information that was tabled with us is a letter, dated December 2, from the Information and Privacy Commissioner, Mr Wright. I'm sure he's watching in right now as we speak. He takes some very strong positions here in his letter. Did you want to comment on that? Have you had a chance to have a look at it?

**Ms Kramer:** I haven't seen it. It was just handed to me just this moment.

**Mr Jackson:** Oh, okay.

**Ms Kramer:** So no, I haven't seen it. Maybe you could sort of précis.

**Mr Jackson:** He laments the imbalance that's created by the legislation, moving decidedly in support of adoptees over birth parents. That's an oversimplification of his page-and-a-half letter, but do you have a response for him?

**Ms Kramer:** Do you mean to tell me that he has a problem with the contact notice not falling within the parameters of FIPPA?

**The Chair:** If you'd like to take a few moments, if you have that in front of you, to just look at it, we can have, as they say, a moment's silence.

**Ms Kramer:** That might be a good idea. Okay.

**The Chair:** It's at the bottom of page 2, I believe you said?

**Mr Jackson:** Yes, the no-contact registry.

**The Chair:** Why don't you just take your time and read that, just so you don't have to get rushed.

**Ms Kramer:** I can't suppose that we could have expected this to go through quite as easily as we might like it to. In answer to your question, however, I think, from my perspective, I should say that we are searching and we are finding and we have been for years and years and years, and at present this would have to be, from that perspective, an improvement over the fact that there's no no-contact registry in place as we speak. Right now, when a person goes out and makes contact with his or her birth parent, there is no mechanism in place that would let them know ahead of time. I think what I tried to say in my presentation is that if there were, we will respect those.

**Mr Jackson:** You're familiar with how staff in the presentation—I believe you were here the day that staff made a presentation to us with respect to how they would be pre-preparing some of the files in anticipation of future searches and also that the automated system, if it began today, wouldn't net any direct access benefits for 18 years. Did you want to comment on both of those points?

**Ms Kramer:** I thought the presentation by Consumer and Commercial Relations was quite good. I was glad to know that they are looking to do something, at least, ahead of time in order to get prepared for this.

I think that we should all note that despite the fact that we have adoption orders that have numbers on them, those numbers do in fact correspond to the original registration of live birth number, which also corresponds to the amended version of it. I know that they keep meticulous records at the registrar general's office, so this should be not too terribly difficult for them to do, as far as I can tell.

**Mr Jackson:** Perhaps if I might have a brief question about some of the implications for additional staffing to assist the backlog. I tend to rather support some of these staff adjustments. There are people in other departments who aren't as busy, and this department tends to traditionally indicate that they just can't keep up with the workload. Ministry staff shared with us the delays and the lengthy periods of time that people are delayed in terms of from when they file to when they actually get some access to the records. I wondered if you had some comments to share with the committee on that.

**Ms Kramer:** It can't be as long as we've been waiting now, can it?

**Mr Jackson:** Well, true enough, but if the legislation doesn't shorten the time frame or increase the access, then why are we really doing it? I mean that as a rhetorical question. I'm glad we're doing it.

**Ms Kramer:** Certainly we don't want to create another mechanism for creating a backlog such as the ADR has become in just seven years. Certainly we don't want to see that sort of thing happen. In a few minutes Mr Macdonald will be in and Mrs Rice will be giving you some figures in terms of how many actual applications for these certificates we can expect here in Ontario.

Projection, it's hard to say. In some countries, less than 10% of adoptees would go and request this kind of information; in others, it's as high as 25%. You have to remember that Ontario has done more adoptions than any other place in North America. They've done the majority of them between 1968 and 1978. Those are the people who are now starting to reach majority, and they are not going to sit and wait.

**Mr Tony Martin (Sault Ste Marie):** Thanks for coming and presenting. Certainly the letter from the Information and Privacy Commissioner is interesting, and I'm glad we have it and that we got it so quickly. I think the important piece of that letter, though, is that the commissioner says the Child and Family Services Act adoption records fall outside the scope of the Freedom of Information and Protection of Privacy Act, so it's not within his scope.

**Ms Kramer:** That's what I've always understood.

**Mr Martin:** However, he does lay out some concerns that he has, as he says, because he has the mandate to offer comments on privacy implications of proposed legislative schemes. I've read through them—I had them over the weekend—and certainly there's nothing in here that we haven't already discussed and that you haven't already discussed ad nauseam for the last however many months and years in putting together the package that we have before us today.

I know that you and others from the associations that have come before us and the individuals have participated in the development of this bill and feel comfortable that we have here something that will take us a distance. In some people's minds it's not the whole 100 yards, but it's certainly significant and gets us to a place where you feel there is some justice being done here.

There's one piece that he does lay out in his comments, though, that I'd like to have some comment from you on. It talks about balancing the right of—

**The Chair:** What page?

**Mr Martin:** I'm sorry, the bottom of page 2. He talks here about this balancing act that needs to take place that certainly others have raised, and he says that in this bill "there would be a positive onus on"—birth parents—"to protect their privacy. You may wish to consider whether the basis of the register should be reversed—that is, the presumption should be that birth parents do not wish to be contacted unless a birth parent expresses a contrary intention. In this manner, those not wanting any contact, or those unaware of the need to register, will not be required to take proactive steps to protect their privacy." It seems to me that what he's saying here is just, "Don't do anything."

1600

**Ms Kramer:** If we look at what could happen if we took that approach to it, we would have a disclosure registry, which is what we have in Ontario, and it's not working, number 1.

Number 2, I think we need to distinguish—and I think there are a lot of mistakes made around this or a lot of misunderstanding around the fact that we've never really distinguished what the difference is between privacy and

confidentiality or privacy and anonymity.

Certainly birth parents need to have privacy from the community. To not be put under a microscope in their communities is one thing. I do believe that's what the law implied when it was originally set forth and adoptions were taking place where birth names were appearing on adoption orders for 60 or 70 years, and even prior to that before we had any kind of sealed records. I think we need to make a real distinction between the difference between a birth mother's right to privacy and confidentiality within the community and at large versus does she have a right to anonymity from a person she gave up for adoption.

I would argue no. In the latter instance, I would say no. The right to anonymity doesn't exist. It may be a need, but needs and rights aren't the same thing.

**The Chair:** Thank you very much for coming before the committee.

DAVID STUBBS

**The Chair:** If I could then call on Mr David Stubbs. Mr Stubbs, welcome to the committee. We in fact will have just about the required time, so thank you for your patience and please go ahead.

**Mr David Stubbs:** I'm here as a united adoptee. My name is Dave Stubbs. That's my legal name. Until I was 15, my name was Dave Hopkins. In the 1960s I was adopted, and I'm still adopted. For the rest of my life I'll always be an adopted person, and I don't have a problem with that. What I do have a problem with is that last year I applied for my birth certificate, and believe it or not, what I received was a true certified copy of my alleged birth registration from the registrar general of this province, and I've supplied you with a copy of that. This document certifies that I was born to my adoptive parents.

The information on this document is false. Not only have the particulars of my birth been falsified and the information not complete, but this falsification has been sanctioned by the government. It has taken me over 30 years to find my birth family, and I've had a relationship with my mother, grandparents, siblings etc ever since. The unfortunate part of this story is that my father passed away seven years before I had a chance to meet him.

I don't claim to know a lot about politics or laws. I'm here because it offends me as a citizen, a taxpayer, a native-born Ontarian and a human being that this government has fabricated my true identity and won't release to me my own real statement of live birth.

I am discriminated against on the basis of the fact that I'm an adopted person. My parents, Mr and Mrs Stubbs, are now deceased. They were good, hardworking, tax-paying people, and they were, as far as I'm concerned, my real parents. They were also very honest people. My father and mother would never have condoned the lies contained on this piece of paper. They taught me as a child it was wrong to lie and, to the best of my knowledge, never lied to me about anything, including my adoption.

I'm sure when they adopted me they were asked to sign many pieces of paper and that they knew nothing

about this falsification. I didn't know about it myself until a few months ago, and I must say I wasn't very happy about it. I want you to understand completely that being adopted is not the problem; being lied to is. Being lied to by the government is unbelievable.

The reason I'm here today is to be sure that no one else has to go through the trouble and pain that I had to go through to find out the truth about myself. You have the opportunity here to change things for the better for thousands of people, not just those who are adopted but for their mothers, fathers, brothers, sisters, aunts and uncles in both the birth and adopting families.

It's the 1990s, and this was the Year of the Family. I'm here today to ask you, as you've been asked for 20 years now, to give us equality, recognize our basic human right to have access to our own birth certificates, unamended, no strings attached.

One thing I'd like to point out on that birth certificate that I handed everybody, if you look at the bottom, it says, on the right-hand side, "I am satisfied as to the correctness and sufficiency of this statement and register the birth by signing the statement...." That's the assistant deputy general. Mrs Stubbs signed, "I certify that the above stated particulars are true, to the best of my knowledge and belief...."

When you're sitting there tonight in the House till 12 o'clock, I want you to think about this and how silly this is. This means that this woman had a child, five foot nine, 140 pounds. If you can figure out how that was done, according to this document, I'd like to talk to you after.

I support this bill wholly. I can see the women laughing because they probably know what the pain is already. If there are any questions, like I say, I don't know a lot about laws and that type of thing; it's just an experience that I've gone through. I know I have a brother who's very happy to see me and a mother who's very happy to see me.

**The Chair:** Thank you for coming before the committee with that particular presentation and as well with the copy of the birth certificate, because I think that does underline clearly a problem. It was clear, but if there are any specific questions? Mr Hope.

**Mr Randy R. Hope (Chatham-Kent):** Thank you very much, David, because you bring a very personal perspective to this piece of legislation. Just in your opinion, because there are others who say the legislation should go further and there are others who say that there should be stronger amendments put forward to this legislation, in your humble opinion, your views, because you indicated it's been a number of years and all that you're asking for is equality, and I know you and we have had communication over the past few years, I'm just wondering how you could express to this committee member and to both the opposition and to the government side the importance of this legislation passing.

**Mr Stubbs:** I think one of the problems—and I watched a TV show a couple of weeks ago and someone put it, to me, right on the button—is the fact that when an adoptee goes looking for his birth mother, father,

whatever, he has a load on him. The first load is, how are my adopting parents going to accept this? Is it going to break their hearts? Am I going to hurt them? I don't want to do that. That's the first thing he worries about. The second thing he worries about is, am I going to be an intrusion on my birth mother? So he has that also, or she has that also loaded on her back.

With all these things that have been loaded on their backs, they worry about everybody else, but it's time we started to worry about us. What are our rights? What are our feelings? Not that we're saying that we shouldn't have feelings for anyone else, but we always say: "What about the birth mother? What about the adoptive parents? What about this? What about this?" What's the sense in having legislation unless it's about us? For once let us have. We're not saying that when we get this thing we're all going to go out like a bunch of banshees and knock on doors and say, "Ma, I'm here after 150 years." It's not going to happen that way. We're civilized people. We just don't do those things. I don't know if you understand that, but we don't do those things.

What it's going to do is give us an identity. People are worried that once you have this birth certificate you're going to be able to find your parents. My mother remarried. The name on that doesn't do me any good. It's a start, but it doesn't do me any good. But I just think that we as adoptees have got to stand up and say: "What about us? Everyone else is worried about everybody else, but what about us?" The only way we can do this is to come to people like yourselves and express ourselves, because I know the majority of people I've talked to who are adoptees, and I know they won't like this, are very passive people. If you tell them, "It's not going to happen; we're not going to give this to you," they'll say, "Well, what am I supposed to do?"

It's unfortunate, but that's the way it is. There are a few of us—and some of you people know that I'm pretty kick-rear-end-minded, that I'm not going to let it sit. I don't represent anybody except Dave Stubbs. I've met everybody. I've nothing to gain by this, but I know what I went through.

**Mr Hope:** So I guess, David, a perfect Christmas gift to a lot of people out in the community would be the passing of this legislation before the House rises.

**Mr Stubbs:** If you people want to be Santa Claus, you've got it in your hands to make an awful lot of people happy, and I wish that you would. I'd take it back to your caucuses, because one of the problems that I've seen talking to people on this issue is they're taking it personally. "I know of an experience. That's why I'm not going to get involved with it. I know about this." We're not looking at one or two that you have had yourself or anybody else. Look at the full picture.

**The Chair:** Both Mrs O'Neill and Ms Gigantes would like to ask a question. I think we can work that in if people are short and succinct.

**Mr Stubbs:** I'll be short.

**Mrs O'Neill:** David, you have made a very powerful statement.

**Mr Stubbs:** Thank you.

**Mrs O'Neill:** You haven't said much about the non-contact veto or register, or whatever we want to call it. I wonder if you would say a little bit about that. You've had reunification, so it doesn't really affect you, but I know you've talked to a lot of people. I think the discussion is hovering around whether the veto should be able to be renewed more than once and also whether the veto should be accompanied by medical history, if it is placed. Could you say a little bit about that from your experience with adoptees?

1610

**Mr Stubbs:** Well, the ones that I've talked to, it's unfortunate, and I hate to say this, but a lot of adoptees, when they say they're looking for people, use the medical excuse. "I think I'm going to die because I have a disease. I think this is what's happening to me. I'm not sure, but I think that this is what's happening to me." I think that as far as the medical thing goes, if there was something serious and these files are updated, the birth parent phones in and says, "I have this and you should get this to the adoptee," I have no problem with that.

As far as the veto goes, if they feel that they do not want to be contacted and it's going to cause them hardship, then I see no problem with it, but I would like to see the actual reason why. Now, a lot of people are saying that they won't put down a reason. It could just be "No." If they know that they're not going to be contacted, then what's the problem if it's not going to happen?

You'll find, and I really believe this and I think speakers behind me will tell you, that this non-contact veto is not going to be an issue. There will not be that many mothers, fathers, whatever, that will veto it. We're not talking 50%. We're not talking 40%. We're not talking 20%, and I think speakers behind me will verify that. It's a very small point to this. They have the right, fine and dandy, but we're making a big issue of this and I just don't think it needs to be there.

Again, I don't know much about laws and that, but those are my thoughts on it.

**Ms Evelyn Gigantes (Ottawa Centre):** Thank you, Mr Stubbs. Ms Kramer referred earlier to the previous discussion that had gone on around reform, the provision of information to adopted people, and I don't think that it's just bureaucrats who've had troubles around this one. I watched that debate earlier and there were a lot of politicians who had a lot of problems around it.

In your experience in working with people—I would have liked to have asked Miss Kramer too—what are you finding in terms of the number of birth parents who will say, "No, I don't want to have contact"?

**Mr Stubbs:** First of all, I don't work with people. I'm just myself as an individual.

**Ms Gigantes:** I'm sorry.

**Mr Stubbs:** There are some people who do. They have nowhere else to go because nothing's really publicized so that they know where to go, so they'll come to me and say: "Well, you found somebody." I have found that for most birth parents, if contacted by the adoptee by phone, by letter, whatever, there's no problem. It's when

a third party interjects and sends a letter on. "How dare you bring up my past? I don't even know you." That's when you have a little bit of a problem. It's like prying into your own private affairs and that's when the problem arises.

**Ms Gigantes:** That would certainly be the case in—well, maybe not. In fact what you're suggesting to us is that there would probably be fewer requests for searches if adoptees had information from their birth certificate and were able to pursue their own search.

**Mr Stubbs:** Yes, I would think that they would. I don't know how many. The biggest problem you find with them is, how do they go about doing it? There's nothing that really tells them, outside of people like Parent Finders and what have you, or any association like that, that shows them how to go about doing it. They could save this government thousands of dollars, because these people can go out and do it themselves without having you have all these bureaucrats going around trying to do it.

The other problem that you find with this—

**Ms Gigantes:** But that essentially is an informal method, which doesn't jibe in a sense with the notion of a veto registry.

**Mr Stubbs:** Again, I say I don't know how many people would actually go ahead and do it. If the mother moves, the mother remarries, the birth certificate does nothing except give you your birth name.

**Ms Gigantes:** And a place.

**Mr Stubbs:** And a place, and a weight and a height, that type of thing. One of the problems I had, on a personal thing, was that the original letter that was going out to my brother was, "We have some information about your birth family, and we'd like to discuss it with you." I had them change it because my concern with that was, what if he, somehow through his life, had a real hate for his mother? It didn't say brother; it said birth family, and the minute he says, "I don't want any contact right now," the search is finished. It's done. It's over.

So I had them send out a letter. It said, "I have some information concerning a birth brother," figuring if he hates me, he's going to say no, but if he doesn't, we're going to get together. Little did I know, nor did anyone tell me, he never knew he had a brother. This caused a whole other circumstance, and it took a while for us to get together, but we're just like two pains in the rear end right now.

**Mr Jackson:** Real brothers.

**The Chair:** Thank you, Mr Stubbs, very much for coming before the committee.

**Mr Stubbs:** I thank you all very much. Please go back to your caucuses and push this thing through. It means so much to so many people.

#### ADOPTION COUNCIL OF ONTARIO

**The Chair:** If I could then call the representatives from the Adoption Council of Ontario. We want to welcome you all to the committee. Once you've had a chance to get some good Queen's Park water, if you would just introduce yourselves for Hansard and the

members of the committee and then please go ahead with your presentation.

**Mrs Pat Fenton:** Thank you, Mr Chairman. We are here to represent the Adoption Council of Ontario. My name is Pat Fenton. My colleagues will introduce themselves as we go.

The Adoption Council of Ontario is a volunteer organization that provides information, support and advocacy for all parties in the adoption process. Since 1987, ACO, as we're often referred to, has established a province-wide membership of over 300. This includes adopted persons, birth parents, adoptive parents, professionals, groups and agencies.

Like our membership and our board, our panel of three today represents the adoption circle; adoptive parent, which I am, birth parent and adopted person.

Through our telephone support line, we have handled over 2,000 calls over the past year from many people within the adoption community. Many of these calls have been from adopted persons and birth relatives who are interested in search and reunion.

I would like to make it very clear that we as an organization support Bill 158 as a first step towards a healthier, more human and humane adoption system for the province of Ontario. We feel that persons who have been adopted have the right to know who they are, to know their family name, not be just a number, and to know who their parents are. We've heard from previous speakers how important this knowledge is to be able to establish a sense of identity, wholeness, freedom and connectedness. We want to base the system on truth, as truth is generally easier to cope with than lies, fantasies and secrets.

As an adoptive parent, although I don't know really what it's like to be adopted, I can't speak for an adoptee, what I do know is that my child, whom I adopted, has from a very early age been very interested to know about her birth family. According to her adoption order, she is a number. No amount of my loving and caring as an adoptive parent can fill the void left by having no name, not knowing her birth parents, and no amount of my loving and caring could give her that sense of wholeness that you've heard from other adoptees.

Birth parents do have a right to privacy. Yes, we support that, the right to refuse to be contacted. For this reason, we support the provision of the no-contact registry. Since circumstances and attitudes can and often do change, the ability to change one's mind about the request for no contact is something that we support.

We would suggest, if a birth parent does register to be not contacted, that she or he be asked to state a reason and that there be an opportunity for an update of medical and social information.

I guess it's the imposition of the fine of \$5,000 to the adoptee upon violation that is the most controversial part of this bill. We've heard it called overkill. Some feel it's insulting to their sense of humanity and human relationships. Others see it as unnecessary, and given the very low likelihood of violation, as you've heard referred to in the research that was done in the New South Wales,

Australia, situation, it probably would be unnecessary. Still others, however, feel that it is important to have some teeth in this bill and, by having this violation provision, that does that.

In spite of this range of opinions, I want it to be clear that there's common agreement among our membership that this bill should be passed and not be held up because of bickering over the penalties and violation.

At this point, Judith Patterson will speak to the birth parent aspect.

1620

**Mrs Judy Patterson:** My name is Judy Patterson, and I am a reunited birth mother. I'm delighted to endorse this proposed legislation. First, I agree with the provision that adoptees be entitled to receive a copy of their original birth registration.

One of the few things, if not the only thing, a birth parent can give a child is a name, and many of us ponder for months over that gift. Then, almost always, and understandably, that name is changed by the baby's adoptive parents. It is important for the adoptees to have their original names.

My birth daughter became a doctor, a specialist, and she went to the hospital where she was born and she went into the room where the medical records are archived and she just stood there, surrounded by names. She knew she was in there somewhere under her original name and she just needed to be there.

Second, with respect to the no-contact clause, I am pleased that it is there for the birth parents who do not wish contact. Some birth mothers are still frightened, embarrassed and ashamed, still remembering the green mark from the phoney wedding bands they wore and still carrying the stigma of a pregnancy termed "illegitimate." For these and other reasons, birth mothers may sign the notice.

This would be an ideal time for obtaining updated medical information and a social history. When I met my adult daughter, the first thing she asked me was, "What nationality am I?" She didn't look like anyone in her adoptive family and she was consumed with a need to know who she was and what she was so she could place herself in the world picture. Until she gave birth to her own son, she had never seen anyone who looked like her. This is the kind of thing that could be included in the social history.

Third, I feel that the likelihood of an adoptee breaking the law by pursuing a reluctant birth parent is very low. The research figures from New South Wales back this up. There are laws in place already to deal with people who harass others, and I feel that there's no need for further sanctions. I feel that giving these adoptees some basic information, medical and social, while not fulfilling their real wishes, will go a long way towards easing their feelings.

Fourth, the signing of this no-contact registry by the birth parent is tantamount to a second rejection of those never-forgotten sons and daughters and, on reflection and as society becomes less secretive about adoption, these birth parents may change their minds. For this reason,

they need an opportunity to reopen the door by removing their names from this list. I am glad the provision is there.

Last, I like the fact that counselling is available but not mandatory. Some people will never want counselling. By eliminating the people who don't want or need counselling, there will be more opportunity for those who do want it. People may want to avail themselves of this option at very different times along this emotional journey.

A bill this long coming and so eagerly awaited needs a lot of publicity so that people will know its provisions and their rights and will have adequate knowledge to make their choices. I applaud this bill and look forward to being in the House when it is read, no matter what the hour.

**Mrs Pat Richardson:** My name is Pat Richardson. I am the coordinator of the Adoption Council of Ontario. I'm a former co-chair and I'm a director of the Canadian Adoption Reunion Register, national office.

I quite agree with everything my colleagues and friends have said in this room. We've all, most of us, been around a lot of years and we have a lot of expertise in these matters. I'm going to speak off the cuff because I want to talk to you about the people whom I don't hear talked about very much right now, and those are my children and the children of all my adopted friends.

I think that I grew up with one hand behind my back. As you can tell, I am not a child. I'm 59 years old, and I've raised three natural children. Those three natural children are now adults and they're out on their own. They're all about to get married and they all will have children, and they need to know what their biological background is.

I think that we have to pay attention to these things. It's certainly been a heartbreak for me when raising them. I would want to be able to tell our doctor something about my medical history to help them, and I could not do that.

I found my natural family in my early to middle 40s. I waited until my adoptive parents had died, as many of us do. I didn't want to hurt their feelings. I was very sensitive about them. They didn't tell me I was adopted until I was 12, so I really gave them a run for their money in my teen years, so much so that I ended up an alcoholic. I've recovered from that and it will be 30 years tomorrow, actually. I looked for alcoholism in my birth family. I found none, so I think it was the pain I went through as a teenager that caused this problem for me and deprived me of many things.

I was very tormented and very unhappy and I just hope that you'll feel in your hearts to pass this law. It's one small step towards our freedom.

**The Chair:** Thank you very much for your presentation. Again, we'll begin questions. Mr Jackson, do you have any?

**Mr Jackson:** Well, what's to say? It was a very cogent, clear presentation from all three aspects of adoption. I guess I'll ask the same question I asked earlier about the amendments, if you've seen them and if

you're comfortable with them. I know you've had an opportunity to look at the legislation. It's very clear, it's well-written. You're not having any difficulty with any of the amendments and that's a comfort?

**Mrs Richardson:** It's housekeeping.

**Mrs Fenton:** Yes, the mechanics of how this will happen. We're looking forward to it happening.

**Mr Jackson:** Good. I can only agree with you.

**Mrs Fenton:** If I could just say that the Adoption Council of Ontario is certainly very willing to help to publicize this legislation, should it pass, and the no-contact registry, through our newsletter, through our telephone support line and through our information sessions that we hold. We are planning as of January to begin the first phase of an Adoption Resource Centre and that could be a vehicle whereby information could be disseminated as well.

Another part I wanted to mention was the fact that we as a council have been working already with the ministry and the children's aid and Parent Finders to help to develop and enhance the peer support network as it relates to search and support services around the province. We look forward to continuing this and we see this as a very important companion piece to this legislation passing.

**Ms Gigantes:** Thank you for coming before us. I'd love to ask Ms Richardson, if I could, you mentioned that you had been associated with, in fact were a founder of, the registry.

**Mrs Richardson:** Parent Finders and the Canadian Adoption Reunion Registry.

**Ms Gigantes:** Right. Do you have a sense of how many natural parents are likely to say no to contact?

**Mrs Richardson:** I've been involved with the adoption movement in this area since 1976 and I think I've had one birth parent say no.

**Ms Gigantes:** So very few, in other words.

**Mrs Richardson:** Yes, I have not had a reunion that—and I think my colleagues in this room would say the same thing.

**Ms Gigantes:** Did you have a chance to look at the—now which one is this? We were given a summary of information from New South Wales. There was a study which had occurred in the early 1990s and there seemed to be a fairly high number of vetoes. Maybe I'm reading this information wrong.

**The Chair:** Is that the one from today?

**Ms Gigantes:** It's numbered page 11, but it's the third page in the memo we received December 5. Is that today? I've lost track of time.

**The Chair:** Yes.

**Mrs Fenton:** We don't have a copy of what you're referring to.

**Ms Gigantes:** There's a column, "Statistics—Adoption Information Act 1990," which is the base for their study. "Applications for original or amended birth certificates from 2 April 1991 to 30 June 1992," and there are over 7,000 applications for the birth certificates.

"Contact veto registrations"—now maybe I'm reading this wrong—"3,432." But under that, it says "Birth certificates issued subject to a contact veto" only "225." I don't know how to read that information. If I just read the first two items, it would suggest that almost half were registering for a veto.

**1630**

**The Chair:** While you're looking at that, I would just note that we got some information on New South Wales and New Zealand which our researcher's put together. Alison Drummond is the researcher with us. Alison, is there anything that you wanted to add just while the witnesses are looking for the statistics?

**Ms Alison Drummond:** I have to apologize. I got this information in a fax from Australia and Providence wasn't clear entirely. It was clearly some kind of summary report put out by the law reform commission, but I don't have an exact reference for it.

The way I read that number—there are plenty of people in the room who know more about this than I do—is that that 225 number seemed to me to be the overlap of people who had applied for their original birth certificates; that of the people who had applied, 225 of them were given birth certificates with contact vetoes on them. That's how I read the number.

**Ms Gigantes:** So you would read 225 out of 7,358?

**Ms Drummond:** Yes.

**Ms Gigantes:** Have you any notion what the 3,432 is?

**Ms Drummond:** I think those were people who had asked for a contact veto to be put on the file, but the 225 are the overlap of the people who had gotten birth certificates with a contact veto on them. That was how I read it.

**Ms Gigantes:** If it's possible to find out a little bit more about those figures, I think it'd probably be of interest to us. Your experience has not been that close to half of people don't want contact.

**Mrs Richardson:** Not at all, ever.

**Ms Gigantes:** Do you think that there's anything in the suggestion that it's easier if the contact is by the adoptee rather than third party, that it's easier for—

**Mrs Richardson:** My view is that it's easier for the adoptee to do their own search. It's much better. It's healthier.

**Ms Gigantes:** It's certainly cheaper.

**Mrs Richardson:** Cheaper, but it's healthier. They learn of it slowly at their own pace, what they need to know about their own background. That's what I advocate. I will help somebody search, but I won't do it for them. Adoptees can do their own contacts, but if they don't want to, then a third person's a good idea. I think the adoptee, as an adoptee, as an adult person—I think that I can handle my affairs in life. We're all adults here and we can handle our own affairs in life. You're allowed to; why can't I?

**The Chair:** Thank you very much for coming before the committee this afternoon. We appreciate it very much.

If I could then call on our next presenters, from Parent Finders Inc.

**Mrs O'Neill:** As the presenters are coming forward, I wonder if we could ask Ms Drummond to try to clarify the information from New South Wales and New Zealand, because it seems to be really contradictory in the things that were given out.

Data on breaches of contact vetoes is the page I'm reading from—it's page 2 of December 2—and it states something that is quite worrisome if it's true. It's only from one author that's quoted, "A survey of several adoption support group members have shown that, from 76 people receiving a veto on accessing information, 75 embarked on a search." If that's the case—and I'm reading only from what I got from the library—this is certainly not what we've been hearing from any of the presenters or from any other information I've had to this point.

I don't know why this person was picked as somebody who was quoted. It goes on even further to explain that 72 were able to trace their parents successfully.

**The Chair:** Perhaps, if I could, just because I'm conscious of the time for the presenters today, there may be a number of questions and, if I might ask, together with the researcher, if some of those could be followed up. Those that still seem problematic we could then bring back to the table tomorrow and getting into them as we start off.

**Mrs O'Neill:** If Ms Drummond what she can take from this, and if it means some phone calls, I think they should be made.

**The Chair:** We'll follow up on that, Mrs O'Neill.

**Mrs O'Neill:** Thanks.

PARENT FINDERS INC

**The Chair:** Welcome to you both to the committee. Please introduce yourselves and then go ahead with your presentation.

**Mrs Judy Rice:** I'd like to first off say thank you for allowing us to make a presentation to this standing committee. My name is Judy Rice and I'm a birth mother and president of Parent Finders Inc. Here with me is Brian Macdonald, a reunited adoptee and the vice-president of our organization.

Parent Finders is a volunteer self-help group committed to all members of the adoption triad. The Toronto branch was founded in 1976. PFI represents some 15,000 persons whose lives are directly affected by adoption. As Ontario's largest search-and-support group, we are dedicated to furthering the interests of adopted persons and their family.

We are a non-profit corporation entirely driven by volunteers whose mission is to reduce the isolation that members of the adoption triangle feel within the community and their families by encouraging support networks and by participating in the search for biological families. As a service, we share with and provide to other organizations resources and consultation with regard to the search process.

You have before you copies of the brief that we submitted over 18 months ago to the Honourable Tony Silipo following the last round of consultations with the ministry. Bill 158 concurs for the most part with our

recommendations, so we submit it again to you, to this committee, both as a detailed statement of our position and as our endorsement of the bill as it stands. Rather than give you a synopsis of our views, we feel it would be more useful to you to present to you the probable effect and workability of these proposals.

To begin with, Bill 158 would grant adult adoptees access to their original statements of live birth. We maintain that such access is a right, but it is also an empowering measure. In practical terms, it would allow adopted persons to search for and contact birth relatives more readily than they are able to do now. It will enable adoptees to act in their own best interests in this crucial area of their personal lives without being dependent on government or social agencies.

We do not foresee new or special problems arising from this access. It will simply expedite search activities that adopted persons have been undertaking for many, many years. However, we do anticipate an increased workload for support groups such as ours, and for this reason, over the past year we have been working very closely in cooperation with the MCSS on a program to improve communication between government and volunteer groups.

This program includes an advertising and public awareness campaign around the rights and responsibilities of those involved in adoption disclosure. These efforts will consolidate existing services and make them more visible, so that those who access their birth information will have an efficient support network available should they require help with search and/or contact. We believe that the contact notice system will work as intended, although we contend that the punitive fine, which some may see as an essential safeguard, will prove unnecessary over time.

Statistics from the New South Wales experience give some idea of how the contact system might work. In its first year and a half of operation, that registry received vetoes from about 1% of the total birth population. Of these vetoes, only 7% came into force by matching with an adoptee's request for his or her birth record. Of this number, no violations were reported.

In Ontario, we can expect the total possible population of 400,000 birth parents to lodge 4,000 notices and of these, about 300 might match with a request for an original birth record. A liberal estimate is that 5% of vetoes could be breached; it means that there would be approximately 15 violations. Projections for the numbers of requests for birth registrations by adopted persons vary considerably. In the United Kingdom, less than 10% of adult adoptees seek the information, while in New Zealand, some 25% of those eligible apply. The Ontario government might expect as many as 30,000 requests from adoptees.

Several members of this committee have commented that this bill, if enacted, could provoke court action. We would like you to consider that court action is almost inevitable if this does not pass into law. During the technical briefing, Ms O'Brien told you that the ADR has a six-year waiting list for service. You should note that this is not a projection, but simply a statement of the

length of time those already registered have been waiting and is incidentally the length of time this service has been in existence. Even with booster funding, the ADR has never completed 1,000 searches in any year. Over 10,000-plus persons are presently wait-listed. This translates into a 10-year-plus waiting list for those who have applied since 1988. By any measure this is unreasonable and we believe that if this bill fails to pass, adoptive persons will have no choice but to petition for writs of mandamus or other remedy through the courts to force the government to provide them with legislative services in a timely fashion. This is especially likely in the case of those adopted persons who are identified by number rather than birth name prior to adoption. These people do not have sufficient information available to them to conduct an independent search and so are wholly dependent upon the ministry if they wish contact with a birth relative.

1640

It is imperative to realize that more people were placed for adoption in Ontario between 1968 and 1978 than ever before or since in North America. These adoptees are now reaching majority and we are convinced that they will not wait patiently on a 10-year list for service. Their choice will be court.

In our view, Bill 158 is practical, workable and acceptable to the clear majority in the adoption community. It is the recognition in law of the right of self-determination for adopted persons, which is long overdue. We trust that this committee will recommend immediate passage to the Legislative Assembly of Ontario.

**The Chair:** Thank you. Did you wish to—

**Mrs Rice:** Questions.

**The Chair:** Then we'll move on to any questions.

**Ms Gigantes:** I'd like to ask, how were the New South Wales figures read? You've obviously looked at them. You've made sense of them, which we can't seem to make at the moment.

**Mr Brian Macdonald:** Interpreting these statistics is a bit tricky because they have a two-way access. So the population of people lodging applications for vetoes is doubled. They have 80,000 registrations of adoption, so they would have a birth parent population of 160,000 as the greatest pool of birth parents who would be able to lodge a veto. Half of the 3,400 number would be birth parent vetoes. So you would have 160,000 people lodging 1,500 vetoes.

**Ms Gigantes:** Now, what do you read that contact veto registration as?

**Mr Macdonald:** Fifteen hundred.

**Ms Gigantes:** Fifteen hundred. Why would you split it down the middle?

**Mr Macdonald:** Well, they say on the next page—

**Ms Gigantes:** Which we don't have.

**Mr Macdonald:** You don't have the same thing. It was split pretty evenly, birth parents and adoptees launching vetoes.

**Ms Gigantes:** All right.

**Mr Macdonald:** Ms Drummond's interpretation of the

225 figure is correct, that those are the number of vetoes that match—

**Ms Gigantes:** The overlap, yes.

**Mr Macdonald:** —with those requests for information.

**Ms Gigantes:** So you would read 3,432 as being veto registrations out of a total potential identifiable population of 160,000.

**Mr Macdonald:** A hundred and sixty thousand birth parents. You would also add in the adoptees for the total population.

**Ms Gigantes:** That's right.

**Mr Macdonald:** Now, one thing that we weren't able to figure out here was how many step-parent adoptions there were. It's difficult to tell. These are the highest possible numbers, and in our Ontario figures we've given the highest numbers as well.

**Ms Gigantes:** Do we have information about the number of adoptions which are step-parent adoptions in Ontario?

**Mr Macdonald:** Two hundred thousand adoptions overall; 120,000 are to strangers. So about a third are step-parent adoptions.

**Ms Gigantes:** I see.

**Mr Macdonald:** And those people would not be requiring information on birth relatives; in rare cases, but we thought it would be negligible.

**Ms Gigantes:** Yes, there might be some cases, I can see. Thank you.

**The Chair:** Thank you very much. I think for many of us we are learning a great deal as we go along and we thank you for the information. Is there any other question? I think not. Thank you both again for coming before the committee today.

#### ADOPTION ROOTS AND RIGHTS

**The Chair:** If I could then call on the representative from Adoption Roots and Rights. Welcome to the committee. Again, if you would just introduce yourself for Hansard and for the members of the committee.

**Ms Wendie Redmond:** Yes. Mr Chairman and members of the committee, my name is Wendie Redmond. I was born Wendie Stipe on April 7, 1941, in Hamilton, Ontario, and was subsequently adopted. I accomplished my own search for both birth parents in 1977 and maintained an ongoing relationship with each of them until their deaths, my birth mother's in 1989 and my birth father's just this past September.

My involvement in the adoption movement began in 1976, when I started the Hamilton chapter of Parent Finders. I was on the founding board of directors of Parent Finders Inc and am a past board member of the American Adoption Congress and the Adoption Council of Ontario.

I am here today to present to you on behalf of Adoption Roots and Rights, a self-help search and support group which is based in the London area of southwestern Ontario. Our membership includes adoptees, birth parents and siblings of adoptees, as well as adoptive parents. I am a cofounder and one of the coordinators of the group.

Our organization fully endorses Bill 158 as a piece of legislation that is long overdue in addressing the rights of adult adoptees to obtain their own birth information. Adoptees were non-participants in the adoption process. Any action or decision-making which led to their eventual placement was done by others who were at the very least cognitive of the situation. Paramount to the process was the best interests of the child. Can continued lifelong secrecy and deception be said to be in the best interests of the adopted adult, who, after all, was and remains the primary client? I think not. Nor have scholarly investigations such as the Garber report in 1985 shown this to be so.

In the years that I have been a part of the adoption community, I have seen bureaucracy and policy as well as legislation change in small increments. I have also seen self-help groups proliferate and continue the work begun in 1974, successfully—one might add more successfully than the government—assisting individuals in doing their own searches and reunions, without government intervention. I have learned, as have countless numbers of us in the adoption reform movement, the value of gaining control over this aspect of our lives.

Present Ontario legislation denies adult adoptees equal rights with other non-adopted citizens. Adopted persons in this province have for too long been expected to accept unquestioningly the decisions made for them by others during their infancy. No other segment of the population is prevented from knowing the truth of its identity.

Unfortunately, there is among us a new generation of adoptee, a category even more disadvantaged by having been assigned a number instead of a surname at birth. These numbered adoptees have no birth surname on which to base a search. They must seek the nameless, faceless persons who gave them life based on their non-identifying background information alone. Some might deem this a hopeless task. It is, however, the only alternative for those seeking self-determination and who are destined to wait interminably on a government list currently backlogged by six years. I ask you to remember in particular these numbered adoptees when you are considering Bill 158.

The dictionary defines "adopt" as "to take into one's family through legal means and raise as one's own child." The Latin route, *adoptare*, means to choose for oneself. I define adoption as an institution invented by society to care for children in their infancy who for a variety of reasons cannot be cared for within their families of origin.

Adoption was not invented to relieve birth parents of parental responsibility; it was not invented to provide children to prospective adoptive parents; neither was it invented to provide employment for social workers and others whose livelihood is linked to the adoption process. Without adoptees, there would be no adoption. That fact is central to this issue. The rights of adult adopted persons must be addressed and Bill 158 would do that.

1650

For me, this is the third standing committee on social development to which I have made a presentation in support of adoption disclosure. The first time was in

1978, when Bill 114, An Act to revise the Child Welfare Act, was under consideration. The second time was in 1984, when sections 157 and 158 of the Child and Family Services Act were being scrutinized. Then, as now, we were asking that adopted adults in Ontario be allowed access to their own information. Meaningful change has been a very long time in coming. We urge you to support Bill 158 in the name of all that is fair, equitable and just.

**The Chair:** Thank you very much. Any questions?

**Ms Gigantes:** I find this topic just enormously fascinating. Can you tell us something about the process of assigning numbers to infants and was it carried out throughout the province? Was there a period of time when it was in use?

**Ms Redmond:** It is now. It's got to do with the adoption order. For those of us who were born between the middle 1960s and 1970, we would have had on the adoption order our given names and birth surname, about which Mrs Patterson spoke to so eloquently. That was the only thing our birth mother could give us, the name which was then placed on the adoption order.

Then there was a change and, as I understand it, it was a policy change—I can be corrected if I'm wrong, which I may well be—written into the Ontario regulations that were attached to the act, whereby the birth surname would be replaced by the birth registration number. It wasn't universally done. We canvassed agencies way back when in the 1970s when I was first involved with this. We canvassed about half the agencies and we asked them, did they use the number. Some of the agencies told us that they always used it, some told us they weren't using it. Some told us it was up to the adoptive parents, they were given the option—would it be a name or a number? Some told us that they—Windsor sticks out in my mind. One of the agencies in Windsor told us they used it if the name was an uncommon one; if it was common, they then just put it on the order. It would depend on the jurisdiction and the policy of each of the agencies. My understanding is there was no regimentation in those years.

Now those people are starting to come forward to us and they're wanting us to help them. They are in the position of having virtually nothing but a background sheet, and those are the people Parent Finders has spoken to you about, who will end up testing the law. I believe that will happen without Bill 158, because these people are a new generation and they are not going to accept the fact that they are numbered.

**Ms Gigantes:** Do you know how many are numbered?

**Ms Redmond:** I would say that the ministry people would probably be able to crunch those numbers for you; I'm sorry, I can't.

**The Chair:** Would you please identify yourself for Hansard?

**Miss Patricia O'Brien:** I'm Pat O'Brien with the adoption disclosure register. I don't know as we would have an exact number of how many were using the first initial of the surname and the birth registration number in place of the full surname but, as Wendie said, it did come

in about the mid-1960s and it was an optional thing, agencies could use it. It's in the rules of court, I believe, not in the Child and Family Services Act.

**Ms Gigantes:** The rules of court?

**Miss O'Brien:** For the legal papers, how they do the—

**Ms Gigantes:** There was a change in the court process?

**Miss O'Brien:** No, it was optional and it is still optional that people, when they are completing the final papers for an adoption, could either use the full surname of the child before the adoption or the birth initial and number.

**Ms Gigantes:** That was not the case up to a certain point in time.

**Miss O'Brien:** No, it was about the mid-1960s that this came into being.

**Ms Gigantes:** Is that right? You just said you couldn't give an exact number, but do you have a rough number in your mind?

**Miss O'Brien:** It would be fairly high, I would think, probably over 50% of the adoptions since that time.

**Ms Gigantes:** So potentially, 50% of people who applied to get their birth certificate could be told that they have a number.

**Miss O'Brien:** No. Their original birth certificate would have their original name. It is only the adoption order that does not have the name. The adoptee's original birth certificate would have the full surname as any other original birth registration would have.

**Ms Gigantes:** Thank you. Okay.

**The Chair:** Just to be clear, if I may, did that end at some point in the 1970s, do I understand?

**Miss O'Brien:** No, I believe it is still an option, but I don't think it is being used as frequently. I think it is still an option when they're doing the final papers record.

**Ms Jenny Carter (Peterborough):** Can that number be used to find the birth certificate? There must be a link somewhere between the number and the name.

**Miss O'Brien:** Yes, it is the registrar general's registration number.

**Ms Carter:** Okay, so they could look it up and find the name immediately.

**Miss O'Brien:** Oh, yes. There would not be a difficulty in locating it, no.

**The Chair:** If I could next call on Valerie Hamilton.

**Ms Gigantes:** It's a little bit early. Perhaps we should leave open the possibility that—

**The Chair:** Perhaps what I'll do then, if our next witness is here—and then we can come back.

JAN SULLIVAN

**The Chair:** Is Jan Sullivan here? I'll call again for Miss Hamilton after.

Ms Sullivan, thank you very much for coming before the committee today.

**Mrs Jan Sullivan:** I would've given anything to be here so I'm very happy that I made it. I am a birth

grandmother. My first granddaughter was born when my daughter was 16. She was named Tanya Louise Sullivan but, under the existing law, as it stands, because she was born in 1973, when she does apply she will be told her name was Tanya Louise S and the number.

There are an awful lot of S's in Canada. It's a bit of a handicap, just a touch, and it's rather upsetting from her point of view. It's horrible to think you've just got a number. People in jail have a number. You have a social insurance number, this number and that number, but when the number replaces your name, I think it's a little tragic.

It's rather hard for a child to give up a child. In my instance, my child was only 16 and she realized that it was in the best interests of the baby. This was not a decision taken lightly. She carried that child for nine months under her heart and as part of our family. It was a very well-thought-out decision and we honestly believed at that time that the best thing in the world for Tanya was to find two parents who had been waiting for a long time. In Tanya's instance, she went to parents that we were told were very similar to us. They already had a four-year-old boy who evidently idolized his little sister and they'd been on the waiting list for two years for a little girl.

We know at the time we did the right thing, and we had no intention of stirring up anybody's family life by insisting that somebody needs to find another family. That isn't what Tanya needs. She needs to take a look at her birth mother and at me and her cousins and aunts and uncles and say, "Gee, I look like that person," or "I look like this person." Most of us look like somebody in our family and it's very interesting, I find even my handwriting is like my mother's. I know I look like my mother and I look like one of my aunts. I took after my Uncle Sid who was an adorable man and I just loved him to bits and everybody would say, "Oh, you're just like your Uncle Sid." But I belonged there. My genes were all part of that family.

Tanya doesn't have that privilege. She's got a family that I know love her dearly. They can't give her the genes, though. They can't give her the looks. One day she's going to need to know about her birth family and when she gets that little form saying, "Well, your last name began with an S and you have a number," it's going to be very disheartening.

1700

What we do definitely need, as Bill 158 is asking for, is please, please, let these people have their statement of live birth. It's theirs. It was given to them the day they were born. They were given a name and the records showed that, in this instance, our little girl was born Tanya Louise Sullivan. It's hers by right and it was taken away from her. She was an infant, so she couldn't speak for herself. Everybody else spoke for her and said: "We're going to change your name. You should be happy about this."

But in that case, as she didn't make this decision, then surely she has the right to say: "I would like to know what it was. After all, I didn't say that you could take this name from me." If you're picked up by the police

and they say, "What's your name?" you give them John Smith and that's not really your name, you could get into an awful lot of trouble there. It's not legal, but if the government does it, it's legal. So it's kind of a difference there.

In our instance, also it's very, very important that Tanya maybe can contact us. We do have some very important medical information that she doesn't know. I lost my paternal grandmother and a paternal aunt to a renal kidney problem that is very preventable. It has to be treated very vigorously. As it so happens, Tanya's aunt, my other daughter, also at 13 this appeared in her medical problems and it was treated and her little boy also seemed to have inherited it. It's very important. It can be treated. It has to be treated properly and vigorously, and in our instance we were able to say to the doctor, "This is what was in the family." It was very treatable.

One of the things that is amazing—I hear again and again—is that you have to fill out, of course, a medical form at some point or other in your life—usually lots of them. I just filled one out for life insurance and the questions—we're talking of a big piece of paper and I was able to answer all of those questions. An adoptee can't. Every question that is on that form with regard to their own personal history is: "I don't know. I was adopted." You simply cannot answer it. "Is there heart disease in your family? Is there diabetes?" "I don't know." As loving as your adoptive parents are, they can't give you their genes. They'd love to. They'd love to hand on everything they have so that it's part of your body, but they can't. It's just simply fact.

Twice in the last month and a half I've spoken to two people who had the most marvellous, loving upbringing in the world, but those two people also had relatives in those families that were doing a family tree. That was when it dawned on them that, up until that point, they were very happy with their lives and, yes, they would like to find their birth parents. But at the point when the family tree came into being, then it became even more important that they had to feel: "Gee, I don't really belong on this family tree. This is my adoptive family. It's not part of my family." So as I say, in six weeks—twice.

The basic thing too is—I don't know if any of you are adopted, but if you were figuring at this point you're going to fill in a medical form and somebody asks you a question, how are you going to answer it if you're an adoptee? If you put yourself in that position, the "I don't know" bit gets to you, you know.

One of the important things too is for the adoptee to ask why. "Why was I given away? Was I a plain nuisance? Was I ugly? Was I a difficult baby? Did you really just have to abandon me?"

I want to be able to explain to Tanya that, "When you were given away, darling, it was because we really thought this was the best for you." Her own mother at this point was very young, still had a lot of school ahead of her and it was purely best for this little girl to go to some loving parents.

I need to explain that. I need to explain it was done with tears, buckets of them. It's not easy either for the

birth mother or the grandparents, even for other close relatives. It's not easy knowing that this is the best thing in the world to do.

I want to feel that Tanya one day is going to be able to find me and I'm going to pick up the phone and a little voice is going to say, "Is that Jan Sullivan, because I think I'm your granddaughter?" I really would like to hear that one of these days and then I'm going to fall apart and phone my daughter.

The closed records were done to stop the birth mother being disturbed. The thing is, though, this child has been disturbed from the day they knew they were adopted and it really is only fair that they still get that point across to the birth mother: "Okay, if you don't want a relationship, it's not a problem. I'll back right off. Here's a picture of your grandchildren." That sometimes knocks down some barriers I've noticed but also, you know: "Okay. I don't want a relationship but could you please fill in this medical form for me? Just where did I come from, what country? What did my grandparents do?" My dad was a bricklayer. It would be nice to sort of feel you are telling this child, "Your granddad was a bricklayer" or an engineer or a policeman or something. It's just that you need all those little things.

Family albums—one adoptee I spoke to when they were flipping through family albums, afterwards a relative said to her, "Of course, this is probably very boring for you because you're not related." Well, this little adoptee needs to find a family album that she is related to the people in that album.

A niece in my family found us two years ago and you have no idea the excitement we all went through. It was just amazing. This was a child that my brother-in-law fathered when he was 17 and he wanted to marry the little girl's mother, but she changed her mind and said no, she wasn't in love with him after all and she gave her up for adoption, but she found us. My brother-in-law got that little call: "Are you Vincent Sullivan? Are you in house building?" "Yes, I am." "Well, I think I'm your niece," and the phone lines between England and Canada just sang. It was amazing just to think that this little girl had found us. We've got another member of the family. It was super.

One of the things that does really chill my mind is that there's always a major possibility of incest. There is always the possibility that there's an attraction and this stranger that you met at the bar or in a dance or at school or whatever, might be your brother. It could just be. I met somebody very recently and he thinks the lady he was dating is his sister and at this point he stopped dead. He hasn't called her. He doesn't know what to do. He met this lady's mother and two or three things started to fall into place and he thinks it's his sister. Fortunately, in this instance, if it is his sister there's no harm done, but there must be cases where there is harm done. The possibility of incest alone means that we've got to start ringing a lot of warning bells and get these records opened so that people know. It's very, very important.

My last little point is, I really feel very strongly. No one has the right to hide somebody's name from them and no one has the right to say, "Well, yes, you were

born. There is a statement of live birth that was made at the time but, gee, I'm sorry, you're not entitled to it," and this is what's happening right now. My Tanya cannot or the other people who are here—I haven't been here all day, probably lots of adoptees—they have not got the right to have that statement of live birth, but it's theirs. It's theirs, so they should have it. That's it. I'm finished.

**The Chair:** Thank you very much. Any questions?

**Mr Hope:** I'd just like to say thanks for the presentation. How much more personal can you get than what you've expressed today? Hopefully, we'll be able to do something to correct some of the problems you've had.

**Mrs Sullivan:** Hopefully, I'll get that little telephone call, eh? As I say, I know I'm going to fall apart.

**The Chair:** Thank you very much for coming before the committee.

**Mrs Sullivan:** Thank you.

**The Chair:** Just to inform committee members, we have had a phone call from Miss Hamilton and she will not be able to join us today. We are ahead, so I'm just going to call the next presenters and if they're not here, we'll take a short recess and come back when they are.

Jonathan Savin and Michelle McColm, are they here?

**Ms Michelle McColm:** Jonathan's about seven foot something. He's very striking. I was really hoping we could walk up together. It's quite an impact.

**The Chair:** You can wait, if he's going to be coming. Your time was at 5:30 and we just have moved ahead. If you want, we can wait. Perhaps what I could do—

**Ms McColm:** Or we could split it, if you want. I don't mind sort of—

**The Chair:** Let me just ask: Is Joyce Ramer here?

*Interjection.*

**The Chair:** If she wanted to go first, then perhaps Jonathan would come in the interim and that way—

**Ms McColm:** We could do the theatrical thing—

**The Chair:** We'll just pause for 30 seconds and see if Joyce is there.

1710

JOYCE RAMER

**The Chair:** Okay, we have Joyce Ramer with us. I want to thank you for being here. We've gotten a little ahead of ourselves, but if you're ready to go ahead with your presentation, we're ready to hear you.

**Mrs Joyce Ramer:** My name is Joyce Ramer. I grew up in a small community in PEI with my grandparents, my parents, brothers, sisters, aunts and uncles. I knew I looked very much like my mother and had mannerisms like my favourite aunt. When I looked at my relatives or the pictures of my ancestors, I could see the resemblance, just as most of you can and your children can, but maybe you take it for granted.

I am reunited birth mother. My daughter Jo-Anne and I were reunited in Amsterdam in August 1993. The match was made June 30, 1993, by Parent Finders. I received the marvellous news July 1 from my contact at Parent Finders following 29 years of yearning, worrying and hoping. It took three years, from November 1990,

through Parent Finders, but I can tell you that after the reunion I wrote to the ADR and enclosed a copy of an article of our reunion. The response to that was a phone call to say that there had in fact been a match made in 1991, but no one called anybody. There was no excuse given.

In July, I was overjoyed and somewhat speechless to talk with my daughter and to receive her first letter and pictures of her growing up. In fact, my aunt thought they were pictures of me when I was younger.

Jo-Anne's adoptive mom was Jo-Anne's contact with Parent Finders in Hamilton as Jo-Anne herself was and still is living in Holland. My daughter and I arranged to meet in Amsterdam the following month, but before that happened, I spoke with her mom on the phone a number of times. She came to Stouffville to meet me and bring a bag of pictures of her daughter's life with their family and her growing up. She also shared stories. Mary said: "There's enough love for everyone. You'll be there when she gets her PhD. You'll be there when she gets married. You'll also be a grandmother one day."

I was left with the feeling that I knew my daughter a little bit before we met in Amsterdam and it was probably the beginning of a long-term relationship. Her mom looked at me smiling when we talked. She was surprised at how much we looked alike and had similar mannerisms.

This is the year of the family; November was adoption month. How appropriate for us to be here today in support of Bill 158. When it's passed, it will allow adult adoptees to have a copy of their original long birth certificate. For adoptees, this is a wonderful piece of legislation, a real breakthrough, especially for those adult adoptees who only have numbers. By the way, I've checked the figure on that and the number apparently is 40,000. The other people affected by this are also those who have medical reasons for finding their birth relatives.

I have in my hand an advertisement that if you go to a research library, you can dig up your roots or find your family tree. The experienced staff, it says, will help you. There is nothing that you can probably think about that they haven't already thought about. It goes from Australia right through to Wales. This is fine for most people, but not for adult adoptees. It says that whether you're a beginner or an expert researcher, the staff are on hand to assist you and answer your questions free of charge. They can find out about their heritage, but not adult adoptees.

In conversations with my daughter and other adoptees, it seems to be a natural longing to know and discover one's roots: your ancestors, your heritage and your culture. This is everyone's birthright except for adult adoptees. Bill 158 will be one step closer to making it an even playing field in terms of rights of one's own background.

The next aspect of the adoption that comes up in conversations is that adult adoptees want to know why. What were the circumstances in the mother's or the parents' lives that forced them into a position where they had to give their children up for adoption? They have a real need to know, for their own sense of self, their identity and their self-esteem.

Reunions are healthy emotionally and psychologically for all who have the courage, the persistence to follow it through to the end. Or is it a beginning? I believe it's both. A recent survey states that of the adult adoptees interviewed, 72% of adoptees said it was a positive experience. I have copies here; my daughter has sent this survey from Holland. This is true whether there's going to be a continuing relationship or not.

As for the aspect of Bill 158 which grants the birth mother the option to state that she does not want to be contacted, I believe this is a very compassionate option, an opportunity for the birth mother. But it must be made mandatory that the birth mother will have the opportunity to reverse this at any time, with perhaps a sunset clause.

In my own case, I probably would have signed, but I would have changed it within the first year, for a long-time family friend, comforting me at the time, told me that I should be prepared to meet my daughter because at any time after her 21st birthday she would probably come looking for me. I have always been open and emotionally prepared to welcome her into my life, no matter what. I did not live by denying her or by telling lies. My friend has since passed away, but his words never left me.

I lived in hope to find out how she was doing, if she was alive, if she had been abused or if she was fortunate enough to be placed in a good family, which I'd hoped and prayed for. She did live in a good home, a home full of love, with her mother, her stepdad, her sister, also adopted, and her niece. Our daughter Jo-Anne is a proud part of our extended families, both her adoptive family and her birth family.

Next summer, Jo-Anne and I will be travelling to Prince Edward Island to a planned second family reunion, a family reunion on our family's part, but first time for her. She will meet her birth grandmother, her aunts and uncles and her cousins. She now can see in the pictures how she does look like the rest of the family. One of the first things she said to me after we met and had a couple of private moments was, "It's really nice to find someone who looks like me."

I have given her a lot of information about her heritage and the genealogical histories of both sets of grandparents. We will look forward to a loving, evolving relationship for the rest of our lives. I thank her mom and her stepdad for welcoming me into their lives and family with such love and understanding. They are a wonderful example of adoptive families who have reached beyond the fear of losing their child in meeting a birth relative to embrace the opportunity to show there is enough love for everyone.

1720

There are a couple of recommendations I would like to make. One would be that the birth parents or relatives should be allowed the adoptive name and address at the time of placement, if they choose to search at a later date.

I further recommend that should the birth mother use the "no contact" clause, she should be required to fill out an extensive medical and heritage information sheet or form, and perhaps a clue as to why the child was placed for adoption.

I also believe that although birth mothers have the right to no contact, the penalty suggested, \$5,000, is far too high. There are already laws that protect a person's privacy. Circumstances change; we must make this clause somewhat flexible and reasonable.

Please pass Bill 158. Thank you for the opportunity to present.

**The Chair:** Thank you very much for coming before the committee.

**Mr Larry O'Connor (Durham-York):** You touched a little bit on it, and I just wondered if you could share for the committee, because you said that the adoptive mother, in this case, initiated some of the work. I think that some of the fears that we're hearing is that the adoptive parents have this fear. You mentioned a little bit about it. I'm sure that since you have met and have been able to be reunited with your daughter, you've talked over some of this. Maybe you could share some of how that personal response was. I think that fear really does turn some people off.

**Mrs Ramer:** It's a real fear. It probably comes out of possession. It probably comes out of the reason for adopting to begin with. Whatever the reason, it's a real fear. But I think that you have to have the courage to go on, if—and these are Mary's words—you consider the adoptee's (a) rights or (b) curiosity, or whatever it might be, her wanting to know, if you consider that, you've got to step back as the adoptive person and say it'll be okay, because you're not losing the child, as Mary says.

I wasn't there in the 30 years that she was growing up, to be there for the aches and pains and all the little things that go on with school and so forth, but what you're doing is you're gaining now in terms of knowing who that person is and what their background is. That's part of the focal point of what adoptees are looking for.

I will never replace Mary, but Mary can never replace me. We've talked about it. It's a matter that I don't think birth families can replace adoptive families or vice versa; I think it's a matter of sharing. There is sacrifice made for time and sharing after a reunion has taken place, yes. That's where we have seen it. You have to get past the fear.

**Mr O'Connor:** As a birth mother being reunited, do you feel any sense of loss that you have to share what you've lost or what you—

**Mrs Ramer:** I can't get that back.

**Mr O'Connor:** No. Is there any remorse to that? Or is some of that overcome now that you have been reunited?

**Mrs Ramer:** I think I dealt with that in the last 30 years. I think what I'm dealing with now is probably making the most of what's forward.

**Mr O'Connor:** I think it's wonderful.

**The Chair:** Again, thank you very much for coming before the committee.

**The Chair:** We are a little before 5:30. Do we have our next representatives?

MICHELLE McCOLM

**Mr Jackson:** We have Michelle.

**The Chair:** Michelle's here. I'm sure if you are expecting Jonathan Savin to be here shortly, we can quite easily recess for a few minutes and—

**Ms Michelle McColm:** I'm okay with starting.

**The Chair:** You sure?

**Ms McColm:** Sure, yes. They're sort of separate presentations. We're sharing the time.

**Mrs O'Neill:** Is Valerie Hamilton here?

**The Chair:** No. She phoned, as I mentioned, and said she would not be coming.

If you would be good enough just to introduce yourself for Hansard, then please go ahead.

**Ms McColm:** My name is Michelle McColm and I'm an adoptee. I think it's hugely appropriate that an adoptee should have the last word today. Jonathan's also an adoptee.

I was born in 1959 and adopted in Toronto at the age of four months old. While I grew up in a very large adoptive family and felt quite loved and accepted by them all, I also felt very strongly that I didn't really quite fit in. I always knew I was adopted. My family was very open about talking about adoption, discussing it. It was very difficult for me as I went through my developmental stages to reconcile the fact that I was told that my birth family was German and my adoptive family ran around in kilts to weddings and so on. In fact, I didn't know what a German was.

There was a clash, there was truly an identity crisis, and I think that's the kind of situation that our, I would consider, antiquated adoption legislation has created. It's created a situation that really no longer fits. I think that as the adoptees from closed adoptions have reached adulthood we can start to talk to them and hear about how that felt, how it was to grow up with that huge dearth of information, very vital information in terms of identity and self-esteem.

I met my birth family when I was about 27. I've met my birth family on both sides, maternal and paternal sides. That includes a trip to Europe, going around meeting relatives who, because I was brought up in a Scottish family rather than a German family, I could smile at but couldn't actually speak with. But it was still wonderful and a very, very healing situation. My adoptive family was behind me 100%—very, very supportive.

After that experience, I researched and wrote a book called *Adoption Reunions*, because I did find that was truly a beginning as opposed to the end of the search for the Holy Grail—I met them and that's it. No, no, no, there's a lot more to it than that. It's a healing experience, but it's a new experience. So I wrote a book and worked in a children's aid society for three years preparing background information, non-identifying information for adoptees and birth family members.

I've also lectured widely and written. I hope you all got a copy of my article that was in Maclean's with my personal story. Okay, so I've written a lot about adoption as well. The upshot of all this is that I'm truly speaking as an individual, as one person's story, but I do know that my story really does segue into and encompass thousands of lives.

As an adult adoptee, let's face it, I'm the only party to adoption who was affected by adoption since conception. Since before I was born, my birth mother, like so many others, knew that she would be giving me up for adoption. It started the day I was born or before.

As adoption legislation was always supposed to be in my best interests, I think it's wonderful that I get to address Bill 158 directly. I really do think that this particular bill certainly is in my best interests.

Working at the children's aid society and seeing adoption files dated back to 1918, I was able to glean a lot of information. Meeting other adoptees and speaking with them, one of the things that I learned is that one of our routes to finding out who we are is to do our own searches. One of the ways to start that search is to take your non-identifying information and become your own detective and search out based on those clues.

Unfortunately, it's absolutely mind-boggling how much of that information is patently false or hugely inaccurate, which sets you off at a disadvantage right from the beginning. If that's the only avenue you have, it's a pretty tough or impossible route to take.

One adoptee whom I know was told that his birth family was in fact deceased, both mother and father. He's met his mother now. I think his father is alive; he just hasn't met him.

1730

Actually, I was told in writing by the children's aid society that I was adopted from—they provided my non-identifying information three years after my reunion, and it was only because I'd met these individuals that I knew people who they were saying were deceased in my non-identifying information were quite alive and well. In fact, I had lunch with them last week. Had I done things in a reverse order and taken that information, it would have been quite difficult and quite traumatic, I think, to try and reconcile those anomalies.

I think Bill 158 directly does address that. In most cases, having looked at these long-form birth certificates, hundreds of them, I know that the information gathered at that time, the one thing the birth mother usually feels comfortable with giving is her name. She might not feel comfortable with saying who the birth father is and she may feel, back in 1959, that to get the child adopted into the best home she has to say that the birth father was some heavy-duty doctor or something, so therefore the information is completely incorrect. Bill 158 really addresses that inadequacy.

You've already heard a lot about adoptees who are now given a number instead of their birth name on their adoption order. That's a point I don't want to rehash, but these are all things that really curtail the adoptee's possibilities of finding out information about themselves.

The other thing that curtails that, one of the mind-boggling things I learned when I was working in a children's aid society, is that at a certain point in time, I think it was the early 1960s, adoption files in children's aid societies across this province were routinely destroyed. I don't mean they were put in synopsis form; I mean actually totally destroyed, do not exist, all that

background information lost.

I can't tell you how painful it was for me dealing with a waiting list of 400 people, to have someone call at age 28, someone who was 30 years old, who's waited that many years to finally get up the gumption to pick up the phone and say, "Yes, I'd like to know what my ethnic background is, and you know, I want to have a child and I need to know my medical information." For me to go ahead and search out that file and have to come back to them and say, "I'm sorry, I can't tell you; there's no way in hell you're going to get that information from me," is a pretty tough thing to have to do and it affects a lot of lives.

So then their next recourse is to go to the registry, of course, and register for a search. Now, that same individual who's taken that long because they were raised in a closed adoption to finally get up the nerve to look for this information is told, "Well, sorry, it'll be about seven or 10 years before we can start your search, which may or may not be successful." Well, do I put my plans to have a family on hold until I'm 40?

There are some really clear decisions and there are some really important things happening in people's lives. We're not just talking about pieces of paper and pushing around information and statutes. We're talking about feelings and people basing their whole lives on very little information.

I guess I do want to say something about the no-contact registry. We were hearing a lot about that, and I do agree with many of the other presenters that it's a wonderful opportunity to gather medical information, if there is a no-contact register. It's also a great opportunity to gather the reason why the birth parent doesn't want contact, and I think that it's only fair, really. It would be extremely cruel to set up a scenario where an adoptee hears that there is a no-contact—and it can be felt as a second rejection to be still kept in the dark about what's happening.

In terms of a breach of a no-contact request, I wish I had four hours to address this one. It's a really fascinating exploration, I agree with you, into the human psyche. Living in a closed adoption system, believe me—the adoptees who reach adulthood today and search for their birth family information, for the most part, if not in every case, have given it a lot of thought. These are not people who are rash or impulsive individuals. Many adoptees, like myself, will wait until their adoptive parents, one or the other or both, are deceased before they search for that information because they are sensitive to the fact that their parents are now 60, 70 years old and they're not going to change the paradigm under which these adults have been adopted and they'd prefer not to even risk the fact of hurting the only parents they've ever known and whom they love. So I waited until my adoptive mother died before I registered. My father was not as threatened.

My point is that these are not impulsive individuals. None of us here can project the future. We don't know why people jaywalk, we don't know why people steal and we don't know why people rape or murder or break any other law, and I can't tell you. I can only give you a tiny course in the psychology of being adopted under closed

adoption and just let you know that I think the search for your birth family information represents a real move towards wholeness and health and mental health and that the individual who's doing that is doing something that has been well thought out. They're searching for self-awareness and an integration of the past and present, and it shows a great deal of thought.

When a positive change like Bill 158 is made, these people who've been denied their basic human rights all their lives are not going to, all of a sudden, start acting irresponsibly or illegally, especially if we can provide them with that reason why there may be a no-contact wish. Look, we can do a little bit of education on it and we've done a lot of research. I've done years of research. We have a great deal of information that says, "Hey, we've all got our own timetables." What's happening now is a real societal shift.

I interviewed one woman for my book who is an adult adoptee who contacted her birth mother, who found her. The birth mother had absolutely no interest in meeting with her. They exchanged letters and a few cards. The adoptee managed to get a list of 32 allergies that ran in the family, and seven years later, roll the film, this birth mother was now finally ready to have a reunion, and they had a wonderful reunion. They remain in contact after four years.

So if there's anything that I want to tell everybody, it's that it's hard to change something that you've been told 30 years ago. You know, "You're an unwed mother and you'll never see your daughter again, so just forget it." It takes a little time. I think that if the adult adoptee understands that—and again, this is an adult, with all the stuff that I've been talking about—I think this can work out for the best, I really do.

There's been some concern raised, because I've been sitting in, on the fact that some adoptees were conceived under difficult circumstances, such as an incestuous situation or rape, and that's true, some have. But in all the contact, again, at workshops, giving workshops, and meeting hundreds and hundreds of adoptees and birth parents across North America, working out of children's aid for three years—at the children's aid I saw about two files that suggested in any way shape or form that incest was involved. It's a rare number of people.

I guess for me, speaking as an adoptee, not just as a researcher, I could name my next book *Oops, I Married My Brother*. I mean, that's happened. At least the birth mother gets to know there was incest happening. The adoptee really doesn't get to know that. I've talked to one male adoptee who grew up beside his birth family, the next house, sat in the same classroom with his birth sister. He thought she was kind of cute, you know, but just did not know.

So it has happened and it will keep happening unless we can rectify that, which is not to say that rape and incest isn't a difficult situation. Of course it is, but we're talking about adults. I think ethically we need to weigh rights. We need to define clearly what is a right. The birth mother who had those difficult circumstances has avenues to therapy, knows where she came from. The adult adoptee has so many, what I would consider, very

primal, basic needs and rights taken away from them by our current legislation that I really think the bill must be acted upon.

Mandatory counselling: I'm really pleased to see that mandatory counselling will no longer be the norm and that it will be provided. I think that it's great that it will be provided. When I went through mandatory counselling, I reacted quite strongly because I was 28 years old and I'd given this a lot of thought since I was six years old. I thought that I'd thought about every angle. I hadn't, of course, but the fact that, as an adult, I didn't have the right to choose my own destiny, that I didn't have the right to decide for myself what was good for me, what was healthy for me, was really patronizing.

I went through my reunion before 1987, and at that time, if I had been 40 or 50 or 30 or 28 years old, it didn't matter. I had to ask my adoptive parents permission to register in the registry. If that isn't insulting and patronizing, I'm not really sure what is.

1740

In any event, I think that adult adoptees grow up under a huge stigma already. I was illegitimate. My mother was an unwed mother. My father was a putative father. I love that word. I was teased at school. I think that to further stigmatize us by asking us to get counselling for what's probably the healthiest urge and act that we've ever done is really a little wacky. But to provide it afterwards is wonderful, because as I found out by researching and writing my book and living this thing, yes, you could use a little help sometimes, but maybe not from a social worker and maybe not from a stranger; maybe from someone else or someone of your choosing.

The fact that Bill 158 will also provide the original birth name, to me, is really integral. Growing up adopted and knowing that you have this alternate identity is a very bizarre experience. Working at the children's aid society, I got to look at all these statements of live births to infertile couples, and I'm going, "Whoa." The Garber report has been referred to before. Ralph Garber referred to these amended birth certificates as "legally sanctioned fraud." I tend to agree. I really do. From my perspective, I think the psychological aspect is even more important.

When I found my birth name on my adoption order, my father was really great about it. He said, "The papers are upstairs," you know, the X files in the metal box, "and you can look at them any time you want," for which I'm eternally grateful. But I still felt guilty. I felt that I was betraying my adoptive parents, so I waited until they were both out. I'm 17 years old and I'm sneaking upstairs and into my parents' room and I'm looking in the files. Seeing my birth name for the first time was just—I didn't even know I had a birth name at that point. I didn't even know what I would find. I found a little bit of medical information, hospital stuff, you know, fontanelles, things you don't even know what they are unless you work in a hospital.

But it was amazing, it was wonderful. "Wow, Diana. Is that really me?" It made my birth family concrete for the first time in my life: "Maybe there's a real woman out there who actually gave birth to me." Of course I was brought home from an agency and my sister was born—

she was a breech birth—to my adoptive parents.

So even the fact that we're not just disconnected from our entire genetic lineage, some of us aren't even convinced that we were born from a woman. I mean, I was hatched; I was convinced of that. So this is the first time I thought, "Maybe someone gave birth to me." What a concept. Pardon the double entendre.

So there I was, and I think that was the first step towards really coming from space and sinking into who I really am, with my wonderful current family and with my past, with my beginnings.

I think that adoptees have the moral and ethical right to know where they came from, and part of that right is knowing their original name. I think it's time to make it a legal right also, I really do.

Society has changed a lot since the first legislation was penned and the laws, unfortunately, haven't kept up with the changes in our culture. In fact, a lot of birth mothers I spoke with said: "I'm really scared to tell my subsequent children I'm going to meet my birth daughter or son. What will my kids think of me?" One birth mother said: "My son's 15. How can I tell him that I did what I'm telling him not to do?" But across the board, these birth parents find out that it's the 1990s. These kids don't have any concept of illegitimacy or unwed mothers. Single motherhood is everywhere, split-apart families, rebled families. You name it, we got it.

My brothers were nine and 11 when I met my birth mother and they were fine. The first thing they said was, "Wow, big sister, that's great," and I hear this over and over again. These are the kinds of issues birth mothers might have about being contacted, but I think that with a lot of care and a lot of love and information and education, this can all come about in a very positive way for everybody.

I'm asking you to consider this bill not only with your heads and your intellects, but with your hearts. I'm asking you to really think if you can, just step on to the holodeck and imagine yourself growing up with nobody who's related to you, no blood relative. You might be 5'2", with the big bump on the nose and the wacky hair and the little bones, and everybody else around you is talking about their breast reductions, and you're going, "Oh yeah, right." You know, you're just not really hooking in there.

So think about what that might feel like. Think about the research that's been done. Think about what we know about psychological realities. Think about basic human rights, and please pass this bill.

**The Chair:** Thank you very much for a very personal presentation. I don't know if there really are any questions. Oh, there are some. Mr Eddy.

**Mr Ron Eddy (Brant-Haldimand):** Yes, I really appreciate you coming forward. I would think that anybody who heard your presentation would be convinced of the importance of supporting this bill, and that's why I feel very strongly about that. I was disturbed to hear you say that some CASs have destroyed files. I'm astounded at that because I've never known that. I thought that they were all there. To my knowledge, they

were. Some societies certainly have them going back many years.

**Ms McCole:** That's true.

**Mr Eddy:** I'm astounded. I'm astounded to hear you say about the misinformation that's been given, to the point of lying. People in positions of trust lying on information to the point of saying that birth parents are dead. How did that happen? How does it happen? Does that mean it's recorded that way or is somebody filling in some blanks? How could that possibly happen?

**Ms McCole:** I think there are many ways that misinformation gets bandied about. Again, I really take a socio-historical perspective. If we blast ourselves back to the past and think about how busy we all were trying to protect each other and trying to evoke the secrecy that is really entrenched in the law, "as if born to," I don't think there was any scrutiny and certainly no legal mechanism to check facts at the time that the information was gathered.

In most of the cases of adoption from, let's say, 1921 up until even the early 1980s, and today in fact, birth mothers have gone through the adoption on their own, and especially in the past, as I mentioned earlier, they may have been trying to protect the birth father. Maybe he's a married man. Maybe he's someone—who knows?—and they may be giving false information with the best intent.

I think the other way this might happen is—this is not going to win me a lot of friends. I saw these files, and part of the mindframe at that time was, "Well, look, these people will never meet anyway." It was believed that the adoptee would never have any desire to know this information. Once you're adopted, you're "as if born to." Your parents are your parents, your family is your family. Well, haven't we changed? So the note-taking was so sparse and so sporadic at times, and files get lost, files get mixed up.

There are any number of ways that can happen, and I think part of it is the protection thing: "Well, your parents are dead." And let's face it, social workers are human beings as well and we all have our own values and mores and so on. If that particular individual believes it's in the best interests to not facilitate a reunion, who's going to stop them from saying that?

**Mr Eddy:** Indeed that's the problem. They're deciding for adoptees and all others connected what's good for them. They see all the information and know more about the person than the person can ever know about themselves, and they're making judgement calls and decisions to prevent people knowing about themselves. I'm telling you, I can't think of a more disgusting situation.

**Ms McCole:** Absolutely. Well, as I said, I prepared this background information. I can't tell you how many times I had to rewrite it, water it down, leave something out that might be disturbing. It was a real—I'm amazed—no, I can't say that on the record. It was tough. It was really tough, yes, to be treating adult human beings like that.

**Ms Gigantes:** But it's the legal framework that's permitted it.

**Mr Eddy:** Yes, unfortunately it was the legal framework. It should never have been the legal framework, but unfortunately it is. I find it so disgusting that we've gotten ourselves into a situation like this where people can't know who they are. But anyway, thank you.

**Ms McCole:** Can you imagine growing up and not knowing your ethnic background?

**Mr Eddy:** Yes, we've been hearing about those situations. Thank you for your presentation.

**Mr Martin:** Yes, I just wanted to thank you as well for such an eloquent presentation and for making some very compelling arguments for us moving forward with this piece of legislation. It's interesting—you've been here through the whole process—that so far, through two days of witnesses, we've not heard one witness say not to do this. As a matter of fact, we've heard witnesses ask for more, which at this point in time I don't think we're in a position to do, but we are in a position to do this, which, I sense from everybody who has come forward and presented, is a first major step forward and an important step forward.

1750

But we haven't had anybody come forward, as I said, who opposes this, and yet I know, from talking to people around this place and in other places, that there is still some uneasiness out there. There is still some sense that maybe this is not the right thing to be doing, maybe there's a violation here of somebody else's rights or whatever.

In your research and the work that you've done, which is rather extensive, and I congratulate you on that, can you give me any reason why the folks out there who might have some difficulty with this have not come forward to express their opposition or their concern?

**Ms McCole:** I think that would depend largely on their personal situation vis-à-vis: Are they adoptive parents? Are they birth parents? Are they adoptees? Are they just people who are afraid of change and maybe not a member of the triad? I think that for each of those individuals, there may very well be a reason. I could probably write a book about that. I can keep you here for five hours.

Adoptive parents can and do feel very threatened sometimes about the possibility of losing their child. All I can do is go back to the statistics that were given—I believe it was for Holland from one of the previous speakers—and say that the statistics that I've unearthed for my book and from my own experience broach something closer to 80% to 90% of reunions being reported as successful. That doesn't mean that there is necessarily an ongoing relationship. What it means is that you come out with more than you go in with. As an adoptee, you come out with more information, even if you have the door slammed in your face, even if your birth mother is dead. You still have gained, as one of the other speakers said, so much by going through that process.

But the word isn't out. The media, especially, likes to sensationalize the negative aspects of things, I think, or, on the other hand, to dramatize the positive. We don't

really hear the realities of what's happening. The reality is, when all is said and done, adoptees will say, "I don't view my adoptive family any differently after reunion," or in fact, "My relationship with my adoptive family is enhanced because we can really be real with each other now; we can be honest for the first time in our lives."

But adoptive parents who don't know that, who may feel threatened by this, those are the kinds of people who are just simply frightened.

As for birth parents, I've talked to many birth parents, I've talked about a few today, who just haven't been able to undo what was—how can I put this?—a very competent job of letting them know that what they did was shameful, that it was punishable for the rest of their lives by the fact that they would never be able to see the child that they gave birth to and in fact had no right to know who was raising them, had no right to know how they were faring, had no right to even know what they looked like. That's a heck of a lot for someone, and then to go and marry somebody else afterwards other than the birth mother and to not tell them because they feel this taint, to think that could be uncloaked and maybe the family that they've finally established for themselves could be blown apart, that would be another reason.

I think there are reasons, but again I think that the overriding thing is that there are some fundamental rights. There's a group of citizens, that is, adult adoptees and adoptees in general, who don't have some of the very basic things that we need to grow up healthy and that everyone else has access to.

**The Chair:** Mrs O'Neill and Mr Jackson.

**Mrs O'Neill:** Michelle, thank you for being so forthright; you have certainly been that. I think you've been a very important witness. I'm sure there's nobody else we've heard from who has got the personal history and then has applied it in their work and occupation. Did you say you're writing a book?

**Ms McColm:** A free plug. I wrote it.

**Mrs O'Neill:** Oh, you've written your book?

**Ms McColm:** Thanks for asking, yes.

**Mrs O'Neill:** That's good. I didn't know whether you were being facetious.

**Ms McColm:** I'm glad I brought it. No, I'm quite serious about my book.

**Mr Jackson:** Where would we get it?

**Interjection:** What's the title?

**Ms McColm:** I love it.

**Mrs O'Neill:** What is its main thrust?

**The Chair:** Perhaps, because you have referred to it, you could just tell us the title and the publisher.

**Ms McColm:** Sure. I'd be glad to. It's called *Adoption Reunions*, subtitled *A Book for Adoptees, Birth Parents and Adoptive Families*.

**Mr O'Connor:** Publisher?

**Ms McColm:** Second Story, here in Toronto.

**The Chair:** Do you want to just hold it up in front of you?

**Ms McColm:** This is embarrassing.

**Mrs O'Neill:** No, it's not.

**The Chair:** No, it's not.

**Mr Hope:** It's a free commercial.

**Ms McColm:** I know. It's hysterical. Okay. Thank you for asking about my book.

The main thrust of it is, after I had my own reunion, and I thought that everybody would live happily ever after, I realized: "Well, okay, so what do I call this person? Do I call her Mom? Do I call her Mrs So-and-so? Where do I go for Christmas?" You know, those kinds of things. Talking to other people who have had reunions, there are so many complexities. You've got a whole new family to try and integrate into your adoptive family. What if she's not calling me enough? Am I rejected again? So I'm exploring those kinds of emotional things that occur. There's a lot of emotional terrain to navigate, and I think that it's quite doable and that it's quite a healthy thing for an adoptee to be able to go through that.

But I think that there's nothing really out there to give some sort of a guide as to: What have other people felt? What are some strategies around making your adoptive parents feel included in your reunion? What are some strategies around resolving your identity? What are strategies around genetic sexual attraction? That's one the media loves to talk about. If you grow up in a family where you don't look like anybody and you suddenly meet someone who looks just like you and they're gorgeous, you may think you're falling in love with that person. There's no incest taboo in place, and it happens. I mean, that happens. We need some kind of a guide, I think, so that's why I wrote it.

**Mrs O'Neill:** You're a very thoughtful, committed person. I'm glad you came.

**Ms McColm:** Thank you. This is the most important half an hour of my life.

**Mr Jackson:** On that note, I can only echo the comments of the other committee members. But would you, please, thank Jonathan for not coming today. It freed you up for a whole half-hour. So whoever this poor Jonathan is, thank him for us because he allowed us to share a full half-hour with you. So on that note, thank you very, very much.

**Ms McColm:** Thanks for letting me go on. You can have me as long as you want or read my book.

**The Chair:** Thank you very much. I'm sure many, if not most, of the committee members will undoubtedly read your book. You said at the beginning that perhaps the best way to end the testimony today was by having someone who was adopted and who had found her family. I think in the 25 minutes, half-hour, we've been together, you have demonstrated that very clearly. So thank you again for being here.

**Ms McColm:** Thank you all, and as Spike Lee said, do the right thing.

**The Chair:** Members of the committee, before we adjourn, just a couple of things. Firstly, Mr Martin, do you want to just indicate—

**Mr Martin:** There's a package of amendments that

the clerk has that you should have that are the ones we will be dealing with tomorrow.

**The Chair:** They have been circulated, I believe.

**Mr Martin:** There is one slight change I want to bring to your attention. It's just a matter of some consistency in wording. On the second-last page in your package, section 176.1, the third-last line in that sentence says, "Original birth registration shall knowingly contact or attempt to contact." Initially that was "shall wilfully contact or attempt to contact." We changed that to "knowingly" so that it would be consistent with the sentence below that under "Same" where it says, "No person shall knowingly contact or attempt to contact," just so that the words were the same. I worked this out with legislative counsel. The word "knowingly" is better.

*Interjections.*

**Mr Martin:** Yes, "knowingly" as opposed to "wilfully."

**The Chair:** We'll be in clause-by-clause tomorrow.

**Mr Martin:** Legislative counsel will be here to answer that maybe more professionally than I, but that's the word we chose, to be consistent.

**The Chair:** Okay. If I could as well just indicate to members that tomorrow we have three other presentations, and again we wanted to try to accommodate everyone who asked, and with those three we will have done so. If there's a need just to have a short break at the conclusion of those presentations before the actual beginning of clause-by-clause, we will do that. We will have plenty of time tomorrow. Just so members do understand, because the House is sitting till midnight—not that I am suggesting that we sit till midnight—there will be plenty of time.

**Mr Jackson:** The gavel will not swing at six.

**The Chair:** No, the gavel will not swing at six, but if we're finished, we're finished.

**Ms Gigantes:** Some of us will have to do House duty.

**The Chair:** I appreciate that. Many of us may have to

do a number of things. But I just want to indicate to everyone that if there are some questions and so on we can deal with those and complete our work tomorrow. Are there any other questions?

**Mr Hope:** Just on that, throughout the presentations we heard emphasis on quick passage. Tomorrow we have the opportunity to think if there is any way that, through this committee, we can expedite the House and quick passage of this legislation?

**The Chair:** The normal procedure, Mr Hope, would be that we would complete our work tomorrow. Then I, as the Chair, would report on your behalf to the House on Wednesday, and then it would be scheduled and normally dealt with on Thursday.

**Mr Jackson:** Can I ask another quick question?

**The Chair:** Yes.

**Mr Jackson:** Do we have the amendments translated?

**Mr Martin:** They will be.

**Mr Jackson:** They will be or they are translated? I know the main bill had to be translated, but I'd hate to find out that translation was holding us up in tabling it. Can you check on that or can we pursue that? I think if we can get those amendments translated as a priority, then we won't get caught with that one. I'm just trying to be proactive.

**The Chair:** We'll do that.

Just briefly, a subcommittee report, the subcommittee has directed me to write to the House leaders concerning the one item that is still on our agenda, Bill 85. I'm just trying to find my information here. Where did it go? Proceeds from crime, here we are. Bill 85, An Act to prevent unjust enrichment through the Proceeds of Crime, sponsored by Mr Jackson. I will be sending a letter tomorrow asking that we look at that during the intercession.

With that, then, the committee stands adjourned until 3:30 tomorrow afternoon.

*The committee adjourned at 1803.*







## CONTENTS

Monday 5 December 1994

### **Adoption Disclosure Statute Law Amendment Act, 1994, Bill 158, *Mr Martin* /**

<b>Loi de 1994 modifiant des lois en ce qui concerne la divulgation de renseignements sur les adoptions, projet de loi 158, <i>M. Martin</i> . . . . .</b>	S-2605
Families in Adoption . . . . .	S-2605
Lloyd LeBoeuf, representative	
Canadian Adoption Reunion Register, Ontario chapter . . . . .	S-2606
Holly Kramer, representative	
David Stubbs . . . . .	S-2609
Adoption Council of Ontario . . . . .	S-2611
Pat Fenton	
Judy Patterson	
Pat Richardson, coordinator	
Parent Finders Inc . . . . .	S-2614
Judy Rice, president	
Brian Macdonald, vice-president	
Adoption Roots and Rights . . . . .	S-2615
Wendie Redmond, cofounder and coordinator	
Jan Sullivan . . . . .	S-2617
Joyce Ramer . . . . .	S-2619
Michelle McColm . . . . .	S-2620

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

\*Gigantes, Evelyn, (Ottawa Centre ND)

\*Jamison, Norm (Norfolk ND)

\*Martin, Tony (Sault Ste Marie ND)

\*McGuinty, Dalton (Ottawa South/-Sud L)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Rizzo, Tony (Oakwood ND)

Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Hope, Randy R. (Chatham-Kent ND) for Mr Rizzo

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

### **Also taking part / Autres participants et participantes:**

O'Brien, Patricia, assistant registrar, adoption disclosure register, Ministry of Community and Social Services

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Drummond, Alison, research officer, Legislative Research Service

CAZON  
XC12  
-577



S-83

S-83

ISSN 1180-3274

## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 6 December 1994

# Journal des débats (Hansard)

Mardi 6 décembre 1994

Standing committee on  
social development



Comité permanent des  
affaires sociales

Adoption Disclosure Statute Law  
Amendment Act, 1994

Loi de 1994 modifiant des lois  
en ce qui concerne la divulgation  
de renseignements sur les adoptions

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
Greffier : Doug Arnott

*50th anniversary*

**1944–1994**

*50<sup>e</sup> anniversaire*

### **Hansard is 50**

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

### **Hansard on your computer**

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

### **Subscriptions**

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

### **Le Journal des débats a 50 ans**

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21<sup>e</sup> législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

### **Le Journal des débats sur votre ordinateur**

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

### **Renseignements sur l'Index**

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

### **Abonnements**

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 6 December 1994

Mardi 6 décembre 1994

*The committee met at 1600 in room 151.*ADOPTION DISCLOSURE STATUTE LAW  
AMENDMENT ACT, 1994LOI DE 1994 MODIFIANT DES LOIS  
EN CE QUI CONCERNE LA DIVULGATION  
DE RENSEIGNEMENTS SUR LES ADOPTIONS

Consideration of Bill 158, An Act to amend the Vital Statistics Act and the Child and Family Services Act in respect of Adoption Disclosure / Projet de loi 158, Loi modifiant la Loi sur les statistiques de l'état civil et la Loi sur les services à l'enfance et à la famille en ce qui concerne la divulgation de renseignements sur les adoptions.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen, the standing committee on social development is now in session. We are examining Bill 158, An Act to amend the Vital Statistics Act and the Child and Family Services Act in respect of Adoption Disclosure. Members of the committee, we have three presenters this afternoon, following which we will move on to clause-by-clause review of the bill. I apologize to those presenters who have been waiting for a while. We had votes in the House and that has delayed the start of the committee, but we will certainly provide you with all the time you were going to have.

WILLA MARCUS

**The Chair:** With that by introduction, I would then invite Willa Marcus to come forward. Just anywhere at all. Help yourself to some water, and may I welcome you to the committee. Once you're settled, please go ahead with your presentation.

**Mrs Willa Marcus:** I was scheduled to speak at 3:30 and I'm getting to speak at 4, so I think we can say that we've been waiting seven years and one half-hour for this bill.

I've come to speak before you to support it. I should tell you that I'm an adoptive mother of a three-and-a-half-year-old girl who we were thrilled to adopt in Ontario when she was an infant. I support this bill very strongly and I want to speak as an adoptive parent in support of this bill. I think it's important that we speak up as well, and I know you've already heard from some adoptive parents along the same lines.

I see this bill as overdue, obviously, and a part of normalization of adoption. I see adoption as a form of a non-traditional family. I know that's a phrase that's used in other contexts, and I see that this is another form of a non-traditional family, which, though it's different from the biological family, is also equal to it.

I would like to address the issues which come before you specifically on this bill and then very briefly address what I see as the very important social context of adoption into which this bill fits and the other forms of stigma and discrimination, which I'll tell you about briefly, which also persist in the law and about which we'll be coming before you and other legislators again in the future.

I believe that adoptees, or as you call them in the bill adopted persons, have a right to the information in their certificates of live birth. I know Holly Kramer would have used that phrase. They are the only people in society who don't have a right to that type of information just by obvious right, and I don't think it's appropriate for them to be denied it.

Aside from the rights question, I also think the research does indicate that it's actually healthy for the adoptee and the adoptive family and the birth parents. So that's good, because even if it weren't, we'd still be left with the rights issue.

As you know, many adoptees and birth parents are seeking to meet each other despite the state of the current law. One of the things that I think is important about this law is that it will bring the law in line with reality. I always think laws are better when they go in line with reality and they don't always. That's why it's quite essential that it be passed, because the situation is going to go on and people are going to continue their own searches, and this at least will, as I said, put some accord between the reality and the law.

I want to address what seems to be the key question here, as I understand, of contention, which is the rights of the birth parents. I actually would like to see a law that goes further than this. I don't believe in the secrecy that attaches to adoption. I consider that's part of the stigma. In fact I would like to see a law where birth parents also have the right to have access to the information in the birth certificate of the adopted child.

I mean, people are allowed to marry and unmarry with no restrictions put on the law of how many times you can change your mind about that decision. You can't change your mind about having placed a child for adoption, but certainly in terms of your desire to have some type of contact, some type of knowledge of that child, I don't think you can say you're going to make that decision when the child is placed and never revisit that decision.

Of course the right of birth parents to secrecy I think must be respected, and I do regard it as a question of secrecy as opposed to privacy. I know Holly Kramer also

addressed this issue of the difference between privacy and anonymity. I think it's a question of birth parents opting for secrecy when they opt for the no-contact registry, but I do believe that has to be respected.

But one of the elements that concerns me is, people are talking about birth mothers. This is a woman's issue, because we are talking about mainly birth mothers, and in fact from my understanding in terms of the searches mainly daughters, but I don't feel that we have a really good understanding of who we're talking about when we say that these birth parents don't want to have the contact. I think that we think we know what we're talking about, and I know that some adoption agencies and the CAS have been called, but I think that there should be some resources devoted to actually figuring out what the precise concerns of these birth parents are, and as I said, I'm not sure that we know. I think that we think we know, but I'm not sure that we do.

I'm not sure whether we have any sense of whether there's any recurring themes that come out if we were to talk to them. For example, we might find that there's a real issue in terms of age. We might find, for example, that older birth mothers feel a certain way and younger ones feel differently, and that might change our view of how we would want to design legislation. I don't know. I'm just making this up. I feel that the adoptive family tends not to be studied except as a form of control group to look at the normal family, and if the adoptive family is understudied, the needs and concerns of birth parents—I mean, they're just not even in the picture.

So when we say we want to protect the birth parents, I agree with that and I agree with those rights, but I'm not convinced that we know what interests we're protecting. I look forward to us moving forward on this whole issue and in fact having more information so that we can then give birth parents rights under this law as well. From that point of view, I do agree with the no-contact registry for now, as I think it's necessary to get the law passed.

I'm a little concerned about the fine. I guess it has to be in there if you're going to have the no-contact registry because it gives bite to the meaning of no contact, but I do think it does leave us in a situation where going around the law, or going around—sort of according reality with the law still becomes an excellent option, because I'll have to say to my daughter, when she has to confront this issue, depending on how she wants to confront it, "Well, maybe you better not go and ask for your certificate of live birth and maybe we can find your birth parents without doing that, because if you're on the no-contact registry, then we've got a whole other set of issues we've got to deal with that we won't have to deal with if we can do this by not getting the certificate of live birth." You have to consider those issues.

This law is really, really late in the game. I mean, as soon as we pass this law, we're going to have to start looking at a bunch of other issues. For example, at least 50% of adoptions in Ontario are international, and I know you're going to say, "That's wonderful, because that's federal jurisdiction." I know; this is Canada and that's the first thing you say, but we have things like the inter-country treaty on adoption and the issues in relationship

to disclosure are going to have an impact on the province, and these are going to make our issues in relation to domestic adoptions in Ontario look like, "Boy, was that ever simple." So once we've passed this, we've got to move on to start dealing with some other issues which are important.

I know when we adopted our daughter we were told about the adoption registry and that she could register and that the birth parent could register, and what occurred to my husband and I was that by the time our daughter was 18, it was likely that the law was going to have changed completely. I don't know if that's the thing that also goes through other people's minds when they adopt, but it seems to me that we should at least put in the law—and I know it's in the law that you have to be informed about the adoption registry.

Obviously it's going to change now, but it seems to me it's important that we put something in the law which means that agencies must tell all the parties to the adoption that not only is the law about disclosure what it is now, but there is this debate going on, and we can no longer tell you that 18 years from now we can guarantee you confidentiality. We at least have to start solving the problems for the future now, and it seems to me it's important that all the parties be told this now, because it's sort of ridiculous. It's like, you know, I wanted to learn to play the piano but it would take 10 years and that was 10 years ago. At least we can start solving the problem of down the road for now.

#### 1610

Now I would like to go, briefly, into my view of one of the reasons not to support this. I mean, I support this bill, but what I'm trying to say is that there is sort of a double edge to adoption disclosure.

The very positive edge is a total rejection of the idea that there's one model of a family, and that's got to be this sort of biological mother and father and children and it can't include a birth parent and there can only be one real mother. My daughter has two real mothers. I am real, and I don't know how I can think of her birth mother as not being real. It's sort of difficult. She gave birth to her, so she's got to be real to some degree. I consider she has two real mothers. Now, this is not your normal traditional family, but I think this is a family which is of equal value and deserves equal respect in society and equal legal rights. So I support all this for that reason.

I don't support it from the point of view of thinking of adoption as being illegitimate and that really what we want to do—I'm thinking of the media image that you sometimes see of the only "real family" is sort of the reunited family. What does that do for the whole time the child was growing up? I don't support that sort of stigmatized view of adoption, which I consider is very negative to the adoptive parents, to the adoptee and to the birth parents.

The history of adoption is that adoptive families have not been treated as equal to procreative families. It's only in the last 40 years that the family law has been changed so that adopted children actually could inherit from their adoptive parents. There was a long period of time where you had both sealed records and adopted children who—

the adopted children inherited from their mother and father, but, for example, in terms of the grandparents, they did not inherit from them. This sends a very powerful message about what your status is in that family.

That law has been changed, but there are still a variety of laws which discriminate against adoption: the Citizenship Act, for example. I know you don't have to worry about that because it's federal, but there's in fact a case that went before the Canadian Human Rights Commission recently where a woman, an expatriate Canadian who lives in Ireland, has four kids, two adopted, two by childbirth, and she went to get their passports at the high commission. They said, "Well, here are the two for the ones born to you, but we've never considered that adopted children are equal to procreated children, and those other two children do not have the rights to Canadian citizenship."

A Canadian human rights tribunal ruled that in fact that was discrimination, the law had to be changed and the tribunal adjudicator said the government did have the right—and I think this is fair—to ensure that the adoption was undertaken in accordance with local legislation and that it created a genuine parent-child bond. This is to make sure it's not used as just a way to get around citizenship law, and still the government is appealing that decision so it doesn't have to change the law.

I think there's also the social stigma just in the vocabulary. It attaches most strongly, I think, to the birth parents. People talk about a woman deciding to keep her child. Well, a woman gives birth to a child and she decides to parent it. I don't think we should make the assumption of an adoption. I think that's stigmatizing to women.

The idea that a child of your own is not your own child: There's a whole sort of vocabulary which very strongly communicates the idea of biological importance, and, for example, even the law. The law refers to "natural" children. I mean, what's an unnatural child? My child's an unnatural one. That I find discriminatory.

I'll just finish up here. Also, there are problems in employment legislation in terms of adoption. While mothers by childbirth were able to retain their jobs when forming families from the mid-1970s, it wasn't till 1990 that women who adopted children were in a position to be able to ensure that they could go back to the workforce. It was just not considered. If you adopted a child, you just did not have needs like you had needs if you gave birth to a child. In fact, the Employment Standards Act, which does affect you people, is still very discriminatory in this regard because non-adoptive mothers are entitled to six months off work and adoptive mothers are only entitled to 17 weeks, even though adoption agencies can require adoptive mothers to stay off the workforce for six months.

These all, to me, fit together as this idea that you have this traditional family and you have this adoptive family, and by "adoptive family" I do include the birth parents. I consider that my daughter has two real mothers. I consider that this law fits into the context of making adoption and adoptive families equal under the law.

**The Chair:** Thank you. Could you just wait for a

second. There might be a question before you go. I think your presentation was very clear. Thank you very much for coming before us and also leaving a lot of issues that I can see we're going to have to deal with later.

FRANK RIOUX

**The Chair:** If I could then call on Frank Rioux. Mr Rioux, welcome to the committee and please go ahead with your presentation.

**Mr Frank Rioux:** I appreciate the invitation to be here today. It's the first time I've participated in this part of the procedure. I've been involved in election campaigns, but never before the House.

My name is Frank Rioux. I was adopted at birth in 1948 and up until five years ago I was not interested the slightest bit in searching. I've done that since and found my birth mother and had a reasonably good reunion. I also found out the heritage I promote, my French-Irish heritage, isn't exactly that of my bloodline, but close—the Irish is there, anyhow.

I've been involved since my initial search in helping other people search as well with the adoption support group of Barrie and I'm a member of Parent Finders here. I believe adoptees need to do that when they feel the urge but I think also, in watching the hearings from last week and reading the transcripts and watching the TV from yesterday, that we've danced around the bill quite a bit in the sense that the bill really addresses a basic right that everybody else has but adoptees do not have, in the sense that we can get hold of our original birth certificate, which anybody else can get and read and have the proper parents at the bottom of that. Mind you, my real parents are my adoptive parents, but my birth parents are still of interest to me.

My original birth certificate is of interest to me because it's me; it's part of my history before I was adopted, whatever it was, the five days before my mother actually got hold of me. I think when we look at all the rights that we're trying to grant most segments of our society, whether they're minorities or visible minorities, disabled people, the gay movement, I think adoptees should have this so very basic right and I would hope that when they sell this in the House to the other members, it is sold on the basis that it is a very basic right that everybody else has.

What we're going to do with this piece of paper when we get it as an adoptee, whether we're going to search or frame it or throw it away, I think is rather irrelevant to the bill. If somebody else has a right, then I think adoptees should have the same right—no more, no less. In terms of the no-contact laws, I think that's good also in the sense that it alerts the adoptee that somebody may not be wanting to see them if that's what they want to do, search. I'm not sure how that fits in with the rest of the family. If a birth parent indicates that they're not interested in seeing the adoptee, what happens to the birth grandparent or the birth uncles, cousins, especially siblings? I'm not sure how they would fit into the equation. Does the adoptee then think that no one in the birth family wants to see them, which is rarely the case. Mind you, it's rarely the case that the birth mother or the birth father doesn't want to see them either.

I was hoping I could tell a little story about former Justice minister, Davie Fulton. I use that example to make a lot of decisions in my life. One of the first election campaigns I worked on was Len Marchant out in Kamloops, BC. I was only 17 at the time and I just put up signs and what not. We were campaigning a fellow against a very powerful member, Davie Fulton—I didn't know who he was, but I knew he was powerful—and we won; I didn't expect that to be the case, but we did.

**1620**

Years later, when Davie Fulton was being interviewed by Peter Gzowski, Peter Gzowski asked him, "Why were you, an anglophone from British Columbia, the Quebec lieutenant in the Diefenbaker government?" He said, "It goes back to the Second World War when I was a colonel and I had a lieutenant colonel working for me who was a Frenchman from Quebec.

"He was the most level headed lieutenant colonel that I've ever met. You know, this even keel, nothing could razz him. So one day we got a memo in French and I calmly said to this fellow"—we'll call him Jean-Pierre—"Jean-Pierre, it would be so much simpler if the allies worked in one language." Jean-Pierre turned to Davie Fulton and he said, "What language would that be?" Davie Fulton said, "Well, most of the allies are English, I guess English."

He said: "This lieutenant colonel went up one side of me and down the other and I stood there with my mouth open wondering: What in the devil have I said? What has angered him? It took two or three days to understand that I was using logic in this case and I had touched on this man's emotions. From that day on, I understood the Quebec issue and that's why I was the Quebec lieutenant."

Using that kind of story with that kind of logic or emotion, you can understand a lot of issues and this issue, of course, for us is very emotional. For those of you who are not involved, I dare say it's hard for you to understand, but it is an extremely emotional issue and it's very, very important to us that it goes through the House so we can get this original birth certificate. I hope it's presented to the House on a basis that it is the right thing to do, it is the same right that everybody else has and we expect these people who are called adoptees to have that right.

A scenario you could use: If two children ended up in CAS care and one was adopted out and one was put in foster care, the adoptee technically could never get, as it stands right now, the original birth certificate. Yet the foster care child, who may have been in five or six homes, can get that. Even though they're siblings, they were basically raised by other parents. Why? I'll leave it at that.

**The Chair:** Thank you very much for your presentation. Any questions?

ONTARIO ASSOCIATION OF  
CHILDREN'S AID SOCIETIES

**The Chair:** I would then call on the representatives from the Ontario Association of Children's Aid Societies. If you would be good enough just to introduce yourselves for Hansard and members of the committee.

**Ms Sandy Moschenko:** I'd be happy to do that. My name is Sandy Moschenko and I'm the manager of accreditation at the Ontario Association of Children's Aid Societies. With me is Elaine Rutherford, who's the supervisor of adoption disclosure services at the Children's Aid Society of Metropolitan Toronto, and Gemma Nicholson, who is Elaine's counterpart at the Catholic Children's Aid Society of Metropolitan Toronto.

Thank you for this opportunity, Mr Beer, to come and speak with you and other members of the committee. I want to say at the outset that I'm here representing the 49 member agencies of the Ontario Association of Children's Aid Societies. We have done what we can to canvass our members and bring a collective position about the legislation. We have also been involved previously in providing input into the forming of the legislation and we are, in general, in support of any efforts to open adoption and the adoption process.

We do, however, have some comments that we would like to make today in an advisory way, and in terms of the process of moving from a system of adoption which has been secret and has ensured the privacy of adoptive parents. We have some suggestions as to how this gap might be bridged, how we can move from a set of social norms that were in existence in the 1950s and the 1960s when many women placed children for adoption, when adoption was the only real alternative for them. Having been in the practice of social work for a long time, I look back to those times and wonder what we will look back on in the 1990s in 20 years and wonder what we've missed.

One of the things we didn't know about in the 1950s and the 1960s was child sexual abuse. Many of the women who placed children for adoption in the 1950s and 1960s had much shame about the fact that they had become pregnant, and in our naïveté I think we failed to notice that some of these women may have become pregnant as a result of sexual assault. We entered into a contract with these women that would ensure their right to privacy: privacy regarding some very, very painful circumstances surrounding their pregnancy and their decision to place their child for adoption. It's this contract that I think we have to really seriously consider in looking at the implications of the legislation that you're contemplating today.

I'm not a lawyer, but I did read with interest the opinion of the privacy commissioner who I believe is sounding a cautionary note about the strength of this contract that we had with women and the implications of violating that contract, regardless of the fact that I am fully supportive of the need of people to know about their heritage and their background. That's the first observation I'd like to make.

Because of the circumstances surrounding pregnancies of these women, this is not a group of people who are going to come forward in a public way to express their opinions about this legislation. As a result, I feel that we have an obligation to speak out on their behalf, and we feel strongly that if this legislation goes forward in its present form there's an onus on the government to publicize the implications of the legislation, not only in

Ontario, but across Canada so that women who might be affected as a result of the legislation have an opportunity to understand the implications and to exercise their rights as they're set out in the legislation. That would be our second recommendation: that there be a broad public education campaign embarked on in order that we can, as much as possible, include in this process the people who haven't been informed of the legislation and aren't aware how it will impact them.

We also want to talk just a little bit about the possible changes to the provision with regard to counselling. We've heard, and I've been present at some of the hearings, their really heart-warming accounts of people who have had successful reunions with members of their birth family. Both Elaine and Gemma could also tell the committee about reunions that weren't so joyous. I don't think any of them, nor I, would have imagined some of the very complicated scenarios that are opened through the process of adoption reunion and adoption disclosure.

We feel really strongly that it is the purpose of counselling or advice to help people make an informed decision about the steps they can take up to and including adoption disclosure-reunion. We're not here to frighten people but we're here to realistically inform them of some of the obstacles, some of the surprises, some of the devastation and some of the disappointments that they could encounter along the way, as well as giving them some encouragement regarding some of the joyous outcomes that can come as a result of reunion.

1630

I hate to emphasize or appear to emphasize the negative aspect of this, but bearing in mind that many children were taken into care and placed for adoption under circumstances that were mandated as a result of the need to protect them, I think these factors need to be borne in mind in trying to anticipate some of the emotional reactions that people will encounter when they do come together. This is where counselling can help to ensure that people are making informed decisions.

I've also heard and I'm very sympathetic to the accounts people have made, of lengthy, lengthy waits in order to get the most simple information about their background. Just as an example, I have on file a letter from the Niagara children's aid society which just crossed my desk yesterday saying that they have on their waiting list 500 people who are waiting for non-identifying information in order that they can help to complete the collection of information about themselves. They have three quarters of a full-time staff position devoted to doing the job of sharing this information, and this scenario is repeated across the province from children's aid society to children's aid society and is in fact a problem within the ministry itself. There simply are not enough staff to be able to respond in a timely way to the needs of people who are looking for adoption disclosure information.

These decisions, in terms of staff allocation, have been made for very good reasons; there are financial restraints and agencies have placed the priority on the protection of children in the here and now. No one could argue that this is a priority that needs to be addressed. By the same

token, having additional funds and staffing in order to be able to address the backlog of requests would, I believe, go a long way to alleviating some of the frustration and disappointment and desperation that people waiting for adoption information realistically experience.

I would like to bring to your attention one additional systemic problem that I think could be encountered as a result of the proposed amendments to the legislation. Children's aid societies over the past several years have experienced an extremely difficult working relationship with the office of the registrar general, not through a lack of trying to resolve problems, but through the fact that there is a system in place at the registrar general's office that simply is not equipped to handle the complexity of requests nor the volume of requests, and I believe the proposals in this legislation are going to exacerbate that problem to a large degree. So I urge you to take a close look at how this problem is going to be compounded, what impact requests for previously unshared information is going to have on the registrar general's office and how, as a system, they will be able to respond to those requests. I think people's expectations will be very high if this legislation passes and it would be tragic to see that there were further bureaucratic obstacles thrown in their way and impediments to them being able to get the information they will feel is now readily available for them.

**The Chair:** Thank you very much. Questions?

**Mr Tony Martin (Sault Ste Marie):** First of all, I just want to thank you for coming forward today. It's the first real challenge we've had to the bill. I know you've been here through the three days of hearings and I think it's important in the interests of democracy and this place and the process that what we do be challenged.

As you say, in some of the material that we got previously and today, I am sure there are a number of people out there who for a myriad of reasons do not feel comfortable or secure in coming forward and presenting what they see as their concerns re this bill. However, I did want to just say a couple of things and then perhaps ask for some response.

One was the issue of this contract that you speak of between a social service agency and the birth mother at the time of giving up the child. I'm aware that in many instances there was in fact some verbal contract made, but I'm assured by those in the field that there were no written contracts that secrecy or that kind of thing would be the order of the day forever and anon.

I guess the question of what weight you put on verbal contracts as opposed to written contracts—and, again, we are dealing here with an issue of rights, and it's sensitive and it's a balancing act that we do. Certainly I'm convinced, as the member who's bringing this forward, that what we're doing here today is in fact levelling the playing field re the rights of adoptees as opposed to the rights of birth parents to for ever and ever keep their identity secret from their offspring. When I'm finished, if you want to comment on that, I would like that as well.

We have done some significant work within the two ministries to respond to your last concern around the frustration that you have experienced up to this point. Certainly that is one of the overriding reasons that we're

here today, this sense of frustration, the fact that the system that we have in place now doesn't work. It doesn't give people the information that they need in a timely fashion so that they can get on with their life. It becomes rather cumbersome and costly in the end, in more ways than one.

We have done some work within the ministries involved, in view of the possibility of this legislation seeing the light of day hopefully in two days, if I have anything to do with it, so that the resources would be there to make sure that this did in fact work, that the two ministries were able to respond in a timely and effective fashion so that it doesn't create more frustration than we have at the moment and in fact reduces that experience and gives people what they need so that we will have more people walking away with the information they need to sometimes do their own searches, which is perhaps what they might choose to do so. We take a bit of the pressure off the system re the searches that would continue to need to be made.

We've also, in the amendments that we've brought forward to the bill, tried very hard to, at this juncture and given this opportunity, streamline the system so that it also isn't as complicated as it is at the moment, the back and forth between various ministries with pieces of information and trying to match things up and the different people who have responsibility for things. We've tried to make it less complicated. I think we've achieved that.

We've tried to also reflect our concern re the question of sensitivity and dealing with people in a way that is helpful as opposed to not helpful. We've put the people side of things, the contact side of things in the Ministry of Community and Social Services, which does that. That's part of what they are and why they exist, to provide services for people in the province in a timely, effective and caring manner. I'm sure in this instance that will be the same so that the other ministry which deals primarily, in our government, with the storage and dissemination of records can do that. That's the job that they do well. Hopefully, with a little relief re this exercise, they'll be able to do it even better. They will as well be given, by the government, some extra assistance to make sure that they're able to do that job if this bill should pass and move forward.

With those comments on the table, I'd now like to hear from you and perhaps have further discussion.

**Ms Moschenko:** I'd like to thank you, Mr Martin. I'd like to respond to your first comment about contracts. You're right, these were not legal contracts. But the practice of social work is nothing if not based on trust. This was a contract based on trust.

Our organization sponsored a one-and-a-half-day consultation last week on civil suits. I don't know if there would be grounds for a person whose privacy was violated in this way to bring suit against the agency or the ministry for having violated the contract that we would keep private their decision to place a child for adoption, but I do think that it's an issue that bears some further examination. I don't know whether my colleagues would wish to respond to that as well.

1640

**Ms Elaine Rutherford:** I think the whole issue of a contract is related to the practices of the day, the general wisdom of the day. The legislation that was in place related to adoption was what guided all the practice of the time. In retrospect, we can look at it and think that was not very wise. I think we know better now. Certainly the openness we're talking about all the time is a positive thing.

The fact remains that there are women we dealt with who came to us at a very, very difficult time in their lives for assistance in planning for their child. They didn't give their children away; they made a plan as best they could given the circumstances. They didn't have choices; they didn't have the supports that women have today. It was a very different time. We made promises to those people as a society, not just as agencies but as a government with legislation and as a society.

We hear from them in our agency. We don't hear from them in great numbers, because they don't come forward and say, "Hello, I'm Mary Jones and I'm a birth mother who doesn't want to be found." We do hear from them when they have been found and they weren't willing to be found. They call the agency. They may be angry about it, they may be just very upset and needing to talk to someone. It is a real issue, not for perhaps the majority, but I would think a significant number. From our point of view, in our agency, we're concerned that they haven't had a voice in this. I don't know how you find that, given that they want to be private, but they're the ones who are going to be affected in a major way.

**Mr Martin:** You know of course that some of the organizations that presented here spoke of themselves as part of the triad of adoption, which includes birth mothers. They've come and spoken very encouragingly in support of this piece of legislation and in fact have worked over a number of years to get us to a point where we have this package in front of us today that has in it the no-contact veto, which experience has told us, and they claim, gives people the information they need to be satisfied in some very significant and fundamental ways that they now know some things that are helpful and are not so driven now to make that contact if in fact the mother has put on the certificate that no contact is to be made.

We're told as well that in circumstances where this cloak of secrecy is there and people are searching and hiring people and going through the process that is so difficult and long and frustrating, in the end, if that's the situation you want to set up, and if you put a complete veto on any information, including the original birth certificate, what you do is cause that person to want to go that extra mile and seek out that birth parent and in fact do what we're trying in some significant way here to have not happen out of respect for this person's right not to be contacted if she so chooses.

We've also made it not mandatory any more, but certainly we've left in place the voluntary counselling that's always been there so that if people do want some assistance in dealing with this particular circumstance or situation, it's there and they can access it and use it. Do

you not think that lowers the anxiety somewhat re this group of people and goes the distance in terms of what we can do given the society we live in today and given the mores surrounding this whole area today as opposed to 15 or 20 years ago?

**Ms Gemma Nicholson:** I guess I'm thinking of a couple of things. First of all, I don't see this as a real challenge to the bill. I see it as saying that there's a very large percentage of people who haven't been heard from. I guess the feeling I'm getting is that you might see us as being against everybody else the past two weeks, and that's not the way it is. If everybody agrees, including these birth mothers you refer to, why hasn't this been given a lot of publicity? I just heard of it because someone kindly called me and said, "This is going to happen." I'm not reading about it. There are a lot of birth mothers who are out there who don't know about it, and you're talking about giving them one year, that from the date when this is proclaimed you've got one year.

People refer to the New South Wales study in New Zealand. I do believe they gave two years in a country of something over three million people. There are three and a half million people in Metropolitan Toronto alone. We're talking about coast to coast in Canada. We need more than one year to tell these birth mothers that, "Your name is going to be given out whether you like it or not."

I agree with everything else as far as reunions are concerned: They're healing; they're healthy. Secrecy is bad; privacy is okay. If there was a way whereby we could somehow get the word out to these women that your privacy, your secrecy, what you lived with for all these years is now going to be given to your son or daughter, whether you want it or not, then that's fine. They're going to have two years or so, and if the government commits itself to the money to publicize this, then I don't think you're going to have a lot of people opposing it. But something that has the appearance of being rushed through—and as you said, this is the first so-called challenge you've had. Why? Why is it the only challenge? Do you know what I'm getting at?

**Mr Martin:** It could be that people are generally okay with it.

**Ms Nicholson:** That's how you would interpret it, and I agree, but we feel that there's a body of people who are not, if they knew about it—do you know what I'm getting at? We're not against it. We're just saying, why can't you give them a little more time rather than two years and why is this going through so quickly? Why can't we just talk about it a little more before it becomes law?

**The Chair:** I just want to indicate to committee members that I want to make sure that people have an opportunity to raise questions and to discuss these issues, because I think this will assist us when we do come to clause-by-clause. If people are looking at the clock, we're going to take the time that we need to take to deal with this effectively. Mr Martin, if you have one more comment, then perhaps I'll pass on to some of your colleagues who would like to raise some issues as well.

**Mr Martin:** Just a couple of things: This is not new. From my participation in it and my reading of what's

happened previously, there have been two fairly wide consultation processes that happened across the province.

**Ms Nicholson:** I'm aware of that, sure.

**Mr Martin:** People have had a chance to participate and contribute to the package that we have in front of us here today, which is a result of all of that. In no way did anybody connected with this bill want to ram it through without anybody knowing about it and without talking about it. Certainly, when we brought it forward for second reading, there was discussion in the House, there was opportunity for people to see it across the province, and if the press wanted to pick it up, it could.

I sent out, because I'm pretty proud of this piece of legislation—I think it's a major step forward in the whole arena of rights and justice and all those kinds of things, good things that many of us in coming to Queen's Park thought we'd be involved in re the making and renewing of legislation as it affects people—a number of press releases around it. Some of them caught and some of them didn't.

**Ms Nicholson:** You're right. It probably doesn't really appeal to a large percentage of the population out there, so they're not going to pick up on it.

1650

**Mr Martin:** I also have had numerous letters from folks of the triad—birth mothers, adoptees and adoptive parents—and as I've said before, I have yet to get a negative letter on this piece of legislation, and that's been over a period now of about six months, I guess, since this was introduced. I've looked at the material that came in that was collected before then. There's no effort here to try and somehow shroud this exercise in secrecy.

I find that yes, it's very interesting that more of the challenging sort haven't come forward, and I thank you for coming today. There's nothing wrong with challenging; that's what this place is about. I hope you're not getting a negative connotation out of that from me. I'm just trying to explain to you where I'm coming from and why I'm supporting this and trying to get a handle on where you're at re your concern. Anyway, those are my comments.

**Ms Nicholson:** I just want to say about that too that I believe that probably 90% of birth parents, birth mothers—birth fathers, unfortunately, don't even know a lot of the times that they did father a child. But the birth mothers, if they knew this legislation was going through, if they had access to counselling, a lot of these women can be made to see that it is a healing thing for them to meet or know about the child they placed. It's just that if an adult adoptee can request and receive that maiden name, that place of birth, do the search on their own and knock on the door, some very good reunions can go off the rails if it happens that way. Probably Elaine and I may have, unfortunately, a little more negative aspect there because it's the people who have the contentious reunions who come to us, it's the people who are having a lot of problems around them.

Because we are such a large country, the feeling of this going through in one year—it just seems too quick. If it was two years even—get the word out that it's going to

happen, and then if they want to feed in, they have the opportunity. You as politicians, we as social workers, we did our bit. We spoke for them. You know what I mean?

**Mr Dalton McGuinty (Ottawa South):** Thank you very much for coming today. We have heard from a number of presenters who have spoken very much in favour of the bill, and I have felt in my own heart of hearts that there's been something lacking here, and for that reason in particular I'm glad that you are here.

First of all, I've said this to Tony off the record and I want to say it on the record: He's to be congratulated for his good work and his courage in attempting to address this issue in a very substantive way.

It's my understanding that this bill goes further than any other province in terms of enabling an adoptee to obtain birth particulars without the consent of the birth parent. It's my understanding as well that in New South Wales they have an additional—I'm not sure how much of a precautionary measure it is, but it says to an adoptee, "We're about to release information to you, but before we give that to you, you are going to sign a formal, legal undertaking that you are not to contact these people if they signed a no-contact order." In New Zealand it's my understanding that if you don't want to be contacted by an adoptee, the veto that you file prevents the state from providing any kind of identifying information to the adoptee whatsoever.

In that context, this bill goes quite far in terms of establishing a right for an adoptee at the expense of a birth parent's right. In fact, the Information and Privacy Commissioner says—he doesn't mince any words about it—on page 2 of his letter to us, "In other words, under the bill adoptees' rights outweigh birth parents' privacy rights in all cases, without exception."

I think that we have a very special obligation to birth parents who are operating on the understanding that they are to remain unknown to a child that they may have given up, under whatever circumstances.

You have experience in this matter; I don't. But I've heard from many of the adoptees who have come forward and made some very powerful and compelling presentations. One of the things I would conclude, in a very inexpert way, is that the drive to know can be very powerful, can be very primal. It can be overwhelming. It can be consuming.

So there was at least one presenter—we haven't had that many but there's at least one—said that she would ignore a no-contact order. The analogy I use is that you take somebody through the desert for three days without water and then put a glass in front of them and say, "Now you can't drink it." What is the practical effect of registering a no-contact notice to an adoptee who has sought for so long, for all the right reasons, to determine where he or she came from and who his or her parents are? Are we setting ourselves up for a fall?

**Ms Rutherford:** If I could try and address that, I couldn't begin to guess about that. I would agree with a lot of the presenters that the majority of people would respect a no-contact veto. Unfortunately, there would be some people who wouldn't. We all know that. I think

many of the people we deal with suffer from mental illness, disturbance. It's a cross-section of the population, as adoptive parents are, as birth parents are. So you can't totally predict that.

One of the struggles that I have—and I do have a struggle with this. I am an adoptive parent, I must confess to that, and what my adult sons need and want is very, very important to me. So trying to sort this out in my own head has been difficult. As I understand it, the amendments to this legislation wouldn't formally recognize the birth parents having any rights. That may be an oversimplification, but that's the way it looked to me. They would have to actively seek proactive protection of their rights.

The comparison is made frequently to adoptive parents and adoptive families being different, and I agree that we shouldn't be, but—I've lost my train of thought. It must have been important, but I've lost it.

**Mr McGuinty:** What if we were to change the presumption in the bill? Right now the presumption is you want to be contacted, and if you don't do something, you could be contacted.

We have a letter from the Children's Aid Society of London and Middlesex. One of the things they describe is how there are a number of people today who are still unaware that there is an adoption disclosure registry, notwithstanding that this has been around for quite some time.

My concern would be that there would be a number of people who would not be made aware of the new law and the new reverse onus. If you haven't done something, you are deemed to be open to contact. That's a positive-onus provision which is very unusual in law. There are many people who don't read the paper and, for whatever reason, will not be reached.

**1700**

What about if we did something that the Information and Privacy Commissioner suggested, we change it so it says that the presumption would be you don't want to be contacted, and if you want to be contacted register a contact notice?

**Ms Evelyn Gigantes (Ottawa Centre):** What's different than what we have now?

**Mr McGuinty:** No, because they will have the birth particulars; they will have the birth particulars in both instances. The only difference is, if you want to be contacted there will be an obligation on you to register that.

**Ms Rutherford:** You mean the birth registration would be available to the adoptee with the understanding that they could go no further than that unless the birth parent registered for contact?

**Mr McGuinty:** No. What I'm trying to say is—maybe you said it right there—that under this bill right now there's a presumption in favour of you being contacted. If you do nothing you're deemed to be receptive to contact. What if we change it and make the presumption in favour of no contact so that if you want to be contacted you have to do something, you have to register.

**Ms Rutherford:** I think that's what the present

register was intended to do. Some of it is lack of enough publicity to tell society about the register, but some of it is that some of the birth parents that we're referring to here who are traumatized by the idea of being found, rightly or wrongly, they avert their eyes from anything to do with adoption or reunion; they hide from it, they pray it's not going to happen to them. It's very difficult.

**Mr McGuinty:** Does anybody else want to comment on that question?

**Ms Nicholson:** The only thought that I had on that was, what birth mother is going to charge her son or daughter \$5,000? Very, very few, if any, even those who perhaps didn't want to be found, because what it comes down to is the whole emotion around being found. In 24 years of doing disclosure I can't think of a birth mother who would have charged her son or daughter for finding her. So that's another aspect of it.

**The Chair:** If you have one more question, Mr McGuinty, but we need to move on.

**Mr McGuinty:** I think that those are all my questions. I know this is a difficult subject and, as I said at the outset, I'm not an expert, but there are some questions that we have to ask, and because we ask them doesn't mean we're against adoptees or we're for birth parents. I think it's because we want to act in the broader public interest. I say that particularly to people who are sitting in the audience.

**Mr Cameron Jackson (Burlington South):** I think the reason we need and are taking the necessary time is because you present yourself to this committee in a very unique position. It would be an oversimplification to refer to you as sort of the "gatekeepers" of the adoption procedure in this province, but in a way that's essentially the role you fulfil. You arrive as the very last deputant after several comments which have cast some of your past activities in a very negative light.

I am currently going through a very, very bad experience for one of my very young constituents who's dying of a disease and we're needing to get family information. I don't think it would be fair for me to raise that, but I come to this committee with some very legitimate concerns about how children's aid societies have acted in some instances, albeit by and large the activities are very challenging.

I want to share with you the fact that children's aid societies are in a very difficult position in this province. You're charged under the law to protect the rights of children in this province who really don't have rights. I'm sorry I have to say that, but my 20 years in children's services have taught me that we really don't have laws to protect children. It strikes me, though, that if we look at an adoptee not as an adoptee but as simply a child in our society who needs rights, something magical happens at the time they turn 16 or 18, depending upon the issue: They move into receiving a whole series of rights as adults that they deserve and have earned if they've survived childhood. But in this one exception, it's one of the few exceptions, over and above institutionalization for reasons of capacity, and clearly that's not the case here, we find ourselves saying to a whole body of citizens, "You continue to retain the

amount of trust, love and respect society gave you as a child," which isn't very much, unfortunately, in terms of legal protections.

So I really am having a hard time, because I don't think it's fair to be critical of the children's aid societies. I think it's fair that it's really important that they attempt to understand the notion of a child's right once they move into adulthood. I will get the name wrong so I won't even attempt it, but at the very opening of these hearings a staff member from the ministry in presentation hit the point, I thought, squarely on the head: This legislation is about shifting the paradigm ever so slightly in favour of the adoptee as a citizen in our society.

That's a painful exercise for politicians, who are professionals at sitting on the fence. The reason legislation is the way it is today is because politicians do what politicians do best: They won't make a tough decision about shifting that paradigm of rights.

I'm prepared to support this bill for the reasons that I've indicated. I'm very encouraged that we have this opportunity to do it. To the point that you've raised, I had hoped that the government would have clarion-called this bill so that we could have had more exposure to it, but it didn't happen. But we at least have a member who has brought it forward and it's before us now.

I want to try and receive from you, and I read your brief, how it is that we can get the children's aid societies to react in a more positive way about how the bill will be shifted. Because I think it's going to pass, I believe it will pass, but you're still the gatekeepers of the system and you're the most critical gatekeepers with information that children need today about their medical records. That may be more or less of a pressing problem if that person is now 40 or 50 years of age, but I know the case that I'm currently working on; it's a life-and-death issue, and the information in the records was not consistent. A match had to be made to save the child's life, and the match uncovered all sorts of information. It was not handled properly.

If there were those forms of abuse—and I don't want to use "abuse" in that legal sense, but you understand what I'm saying—over those years in those records, do we not owe them the concept of an attempt at a match in order to give them the same rights I have as an adult in my society? That's really all I'm asking the children's aid societies to do.

Can I get your reaction to that, please?

**Ms Moschenko:** I'd like to respond to that. Mr Jackson, I think there are some provisions in the current legislation with regard to medical needs and medical information that go beyond the routine. They may not be adequate, but there are provisions in the legislation currently.

I don't deny that adult adoptees have the right to have this information and I feel they're entitled to having it. All we're proposing is that the process of including the silent partner in this triangle be considered.

I would, however, like to comment on a present-day adoption practice and some really serious obstacles that continue to exist in the legislation that prevent children's

aid societies from doing some of the things that you're mentioning. Probably the largest is that under the Child and Family Services Act a child who is a crown ward and who has a court order allowing access to his or her natural parents or other members of his or her family cannot be placed for adoption. This often works against the ability of the society to make long-term plans for a child, and this is a piece of the legislation that I think urgently needs some attention, in order that in 20 years we're not sitting here again talking about similar violations of the rights of adoptees.

1710

I know that people working in the adoption field would like to have what's referred to as the option of arranging open adoptions, but unless legislation is changed, it prevents us from exercising this option to its fullest and in the best interests of these children.

**Mr Jackson:** In the interests of time, I'll yield, but I do appreciate you being here and had hoped that we'd have had a little more time to get into some of these issues. Thank you.

**The Chair:** Ms Gigantes and Mr Eddy, and that will conclude this part.

**Ms Gigantes:** I have a confession for you. I've certainly told the committee before but I also have an adopted child, now 27, so I do have a special kind of interest in the subject area too, and I think that Ms Marcus earlier referred to much of the issues that we deal with in this question as women's issues. She also indicated, if I heard correctly, that a lot of the adopted people who look for information about birth parents are female. Is that your experience?

**Ms Moschenko:** That's right. Twice as many.

**Ms Gigantes:** Twice as many?

**Ms Moschenko:** Yes.

**Ms Gigantes:** I've never heard that before, so that's kind of interesting. I really do think it's a women's issue, and the debate that I was familiar with back in the late 1970s around increasing the amount of possibility for adopted people to find birth parents through the registry and so on has shifted. Originally it was the protection of the adopting family that was the huge issue around this Legislature, and we had very stirring debates on that subject here in the late 1970s.

Now I think we've come down to a different point in it all. It kind of makes you wonder about the degree of delicacy around all this stuff. It doesn't matter which way you turn; we're always going to find somebody who presents some reason why people shouldn't know, it seems to me, but it's now the birth mother, and I have a great deal of sympathy with that because I think that your description earlier of the social setting in which adoptions took place as late as 15 years ago was one in which there was still so much stigma and so much sense of secrecy and hiddenness and shame and all that jazz, that for a lot of the women who might now feel vulnerable on the revelation of certificates of live birth, it would feel as if the world had shifted from under them.

I know that there are such women, and I agree with you that they are not the witnesses before us, though they

exist. None of us really knows how many they would be, and I think we have to make a choice, and my choice would be to support moving ahead. I wish there were a way, and I'm sure you wish there were a way, and I'm sure we all wish there were a way that somehow a woman who has given up a child 20 years ago or 25 years ago—I use the old phraseology “giving up the child”—who gave birth to a child who was subsequently adopted, could be forewarned, and our system just doesn't permit that. Our recordkeeping doesn't permit it. Our institutional apparatus doesn't permit it. We can't do that. We can't accomplish that. If we could, I think we'd all choose to do that.

So we have to make a choice, and I think that at this stage the choice, not only because of the need of people who've been adopted to search for their own history and a sense of their own blood relations, but also because in doing that, we change the atmosphere in which adoption occurs in this society. We take another layer of secrecy off it, which I think is an important thing to be doing, and I think we encourage the setting up of systems that in the future can be more sensitive.

I think you've really raised the issues in quite a telling way. I think one of the things perhaps people who haven't been in a family which has been touched by adoption might not recognize is the fear that exists among people who've been adopted about finding out the truth: “What is my birth mother really like?” The worst possibilities are there in the mind. The worst fears are there.

I think, given that truth—and that's always going to be true—nobody who's been adopted is going to have rose-coloured glasses about the possibilities. If you're going to go to the soul-searching effort to look for a birth parent, you're going to realize all the possibilities that you can hit, and you can imagine some pretty fearful ones, and I think a no-contact provision would be respected for that reason. The problem is the cases where the mother who's given birth doesn't know to put the no-contact notice forward. I wish I could think of a way around that.

I don't know that two years would make a mighty difference. I don't know that an extra year would make a mighty difference. I can tell you that people are aware of what's happening, that birth mothers out there are aware, because strangers have contacted me. So they are aware. The word does get around. I'm sure that there are cases where people are afraid to even look at a notice in the paper, but the word does get around.

**Ms Moschenko:** I would just say that even the most effective public education campaign won't touch everyone and that whatever efforts we do to announce these changes need to be done in a way that tries to think of how we can reach out to those people who are most isolated and least likely to know about this, and offer them some support.

**The Chair:** Final question, Mr Eddy.

**Mr Ron Eddy (Brant-Haldimand):** Thank you for coming forward, because it's very important that you be here and give your views. I thank you so much for saying that you are in favour of the bill. You've said that more than once and that's very important, because your role is very crucial. You're seen as the gatekeeper, the firing

line, the stumbling block by many people who want to be reunited and to have the information that they should have been entitled to and that should have been tagged to them at the time of adoption, if I can use a nasty term like that, but I feel very strongly.

You've been criticized; you are criticized. I can speak this way as a former CAS board member for many years and the concerns I had in that role. But we've been told that adoption files have been thrown out, destroyed; that misinformation and lies have been given to people. You've confirmed that not only are there long waiting lists of people wanting birth information but there are long lists of people who want non-identifying information and can't get it.

What a distressful, terrible situation. It shouldn't be. I know why you can't do that. You don't have the money. I don't know why we can't look at a volunteer system and something couldn't be done in this regard to give it. It's so distressing. It shouldn't be happening in our society, but it is happening and I know the concerns and the budget restraints that CASs operate under. You have to decide to do the most important work first or at the time it's needed.

1720

So I understand your situation in many ways, but there is such a great need. One of the things that I see about birth parents, and indeed adoptees, is that perhaps you become more tolerant as you go through life and many people are more willing to face the facts. That's why reunions are possible and do happen. It's living with a situation for years and you change your attitude towards it.

You mentioned about unhappy reunions, but I don't think adoptees are looking for happy reunions. It's nice if it's a happy reunion; maybe it's unhappy. It's the important point of knowing the facts and knowing who the hell you really are and your heritage. That is so important in life. I speak that way because I am adopted.

**The Chair:** I would like, in thanking you for coming before the committee, to just note that we realized in going through these hearings that there would be perhaps some concerns that would not be expressed because of the nature of the issue and perhaps those who wouldn't come forward, and prior to our session with you we had agreed that we would try to ensure that we could explore the concerns that were expressed and allow members to ask questions. I just want to say that on the record because we have taken a longer period of time, but we thank you for coming before the committee today.

**Ms Moschenko:** Thank you for the opportunity to explore this complex area so thoroughly. I appreciate it.

**Mr Randy R. Hope (Chatham-Kent):** Before we move into proceedings and dealing with the amendments and that, it seems like the main issue is notification to the broader public. When the House is not sitting, nor is the committee sitting, the legislative channel presents a picture of the Legislature. I'm wondering if it would be possible that, instead of showing a picture of the Legislature, we start to identify an important piece of legislation which is non-partisan, which is for information of the general public to know as knowledge.

It's important that these proceedings be repeated a number of times through the winter or through the intersessions while committees are not sitting, while the television is not being used, or that a communication strategy be developed. You as well as I do that the best word of mouth usually helps the flow of information. Neither newspapers nor TV help, but word of mouth does.

I think it's our role as a committee, as we heard presented to us in this committee both the rights of the adoptee to know and the birth parents to know their rights—it is our obligation, whether it be through reruns of this committee on a continuous basis or a presentation to the Speaker asking the Speaker for consideration, which I know would be unprecedented, allowing this bill particularly to be communicated to the broader public.

**The Chair:** I think you make a very valid point and perhaps what we might do is reflect on that as we go through the clause-by-clause. It would certainly be quite in order, if the committee so desired, to ask me on the committee's behalf to write to the Speaker. I know that this issue about using that channel to convey critical information is one that a number of us have thought about. I think often we see that channel sort of sitting there and that there could be better uses.

So I wonder if we could sort of say to people, let's think about that as we go through. Then before we adjourn, let's come back to that and, if it's the desire of the committee, I could then on everyone's behalf send a letter requesting that it at least be looked into.

**Ms Gigantes:** I was going to suggest, it just struck me while Randy was talking, that in fact if the groups that are interested in this legislative change exist across the country, which they appear almost to do, they might be interested in having access to tapes of this discussion. They could have cable television run in other provinces, which would provide a free method of advertising in other parts of Canada about the changes that were happening here in Ontario.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I think it's very serious that we do make an intent and a request. There are several of the groups that have presented—certainly the Adoption Council of Ontario and, I presume, their parent body in Canada—that would be very willing to cooperate.

I feel so strongly about the knowledge being up to date that I actually think we should request that funding be directed, which is a recommendation the CAS made. I know that's not within this committee's purview, but we should have a video, we should have everything that can go with this. We don't have that now. We have, what should I say, brochures and a few things, but I haven't seen one thing on TV about adoption from this government. I might have missed it, but I don't think it's there.

I think whatever strength you can put into a letter about getting cooperation from all of the major players and cooperation in the form of a real commitment by the government—I'd be very happy to help formulate such a letter.

**The Chair:** Okay. I think we can come back to that.

If there is a need to draft a letter and get the subcommittee to approve it, even tomorrow morning, just to make sure that it says what we want to have it say, we can do that. I wonder if we shouldn't go on to the clause-by-clause and then come back to that at the end.

**Ms Gigantes:** Yvonne did miss it, apparently.

**The Chair:** Okay. Has everyone got their document in order? We'll just pause for the legislative counsel.

The first amendment is the government amendment, and, Mr Martin, if you would like any or all of the officials to be at the desk, if that would perhaps facilitate if there are any questions, we could perhaps do that.

**Mr Martin:** Yes, I could.

**The Chair:** Could I invite the government officials perhaps just to sit at the table and that would just, if there are any questions, make it easier.

Mr Martin, do you want to move the first amendment?

**Mr Martin:** I move that subsections 28(6) and (7) of the Vital Statistics Act, as set out in section 1 of the bill, be struck out and the following substituted:

"Exception

"(6) Despite anything else in this act, a person whose birth was registered in Ontario and in respect of whom an adoption order was registered under subsection (1) or a predecessor of that subsection is entitled, on application and payment of the prescribed fee, to obtain a copy of the original birth registration from the registrar general.

"Conditions

"(7) Subsection (6) applies only if the person is 18 years of age or older and produces evidence of identity that is satisfactory to the registrar general.

"Notice, birth parent's wish not to be contacted

"(8) If a birth parent has filed a notice that has become effective under section 165.1 of the Child and Family Services Act, the registrar general shall give the notice, or the information contained in it, to the adopted person together with the copy of the original birth registration."

1730

**The Chair:** Any discussion on that, Mr Martin?

**Mr Martin:** Most of this is a package that streamlines the system. If there's anything particularly technical that you want re that one little piece, I'm sure the staff are willing to present it. But at this point, unless there's a question—

**The Chair:** If there's a need for that; not that I don't want people to speak, but if people are comfortable with that amendment, we don't necessarily need to—

**Mr Martin:** Explain it.

**The Chair:** —go through it. But I'm in your hands. Is there some particular point that ought to be—no? Okay. Then I'll ask if this amendment shall carry.

**Mr Hope:** On a point of order, Mr Chair: Just looking at the Liberal motion, is this an amendment to the government motion?

**Ms Gigantes:** No, it comes after.

**Mr Hope:** It's amending it, so you'd have to deal with this amendment first, prior to dealing with the government motion that's being put forward.

**The Chair:** Ms O'Neill, before we place that, do you want to place your amendment?

**Ms O'Neill:** I'd be glad to do that, if this is the proper time.

**The Chair:** Yes, it is. We'll discuss that and vote on that, and then we'll vote on the main motion.

**Ms O'Neill:** I move that Mr Martin's motion replacing section 1 of the bill be amended—

**Ms Gigantes:** I'm failing to follow this process. Mr Martin's motion deals with 28(6), (7) and (8), and Ms O'Neill is proposing to add a 28(9). How can you add a 28(9) before you have a 28(6), (7) and (8) established?

**The Chair:** My understanding is that this adds on and is therefore an amendment and so has to be dealt with first, and then we move to the main motion. It's just that this will form part of 28. We are making an amendment to 28 and so we would deal with this amendment to the government motion.

**Ms Gigantes:** It doesn't make any difference, I guess.

**The Chair:** I don't believe that in that sense it does. Sorry, Ms O'Neill, would you—

**Ms O'Neill:** Okay. I'm not used to amendments that identify members of the committee, but this is the way legislative counsel prepared this for me, so I'm reading it in. I don't remember ever reading in an amendment that indicated—but anyway. It isn't a government motion, I guess, so that's the problem.

**The Chair:** It's a slightly different situation.

**Ms O'Neill:** I move that Mr Martin's motion replacing section 1 of the bill be amended by adding the following as subsection 28(9) of the Vital Statistics Act:

"Reasons and medical information

"(9) The registrar general shall also give the adopted person any information provided by the birth parent under subsections 165.1(3) and (3.1) of the Child and Family Services Act and disclose to the registrar general together with the notice; if no such information was disclosed, the registrar general shall advise the adopted person of that fact."

I speak to that because it does seem that it would be a very convenient place to gather information, particularly health information, and there were quite a few presenters who talked about that. There were quite a few presenters also who felt that there would be, what should I say, help if they had the reasons, so if the question was asked again now and it was actually part of the process as a matter of course, then I think there may be people who would place the reason and I do think most people would place any relevant health information and both of those things would add to the finding of the adoptee even if there is a request for no contact.

**The Vice-Chair (Mr Ron Eddy):** Thank you. Any discussion?

**Ms Gigantes:** Could I ask what the implication of that would be?

**The Vice-Chair:** Yes, would you go ahead and respond, please.

**Ms Joan Belford:** We don't have a problem with it

from a policy point of view. I think that a number of deputants have raised the issue and it would not be a problem for us to ask people to put that information on. It would be a problem for us if it was required and if we were somehow to have to track it down and prove that it was accurate and do various kinds of logistics like that. I don't think there's any problem for us in designing the notice application so that we can collect the information.

**The Vice-Chair:** That's fine.

**Mr Hope:** Just with that, I'm sorry, I was not paying attention. It's the first time I've seen these amendments, but I don't want to prolong the bill. I want the bill to proceed. You said there might be a problem in identifying whether the medical information is factual? Help me with this on your comments. Could you repeat yourself?

**The Vice-Chair:** Yes, I think you clarified it; it's not the way Mr Hope is saying, so would you repeat that explanation? It was the point that you don't have a problem with it because it's not required. It's optional rather than mandatory.

**Ms Belford:** Yes, the motion put forward is optional and that would be fine with us. We can design the application in such a way that it will collect any information that the birth parent is willing to give. We would have a problem if it was required because we then probably would have to try to track it down or get people to give it when they were reluctant, and we wouldn't know whether it was being given under protest and therefore wasn't accurate, that kind of problem.

**The Vice-Chair:** Anyone else? All in favour of Ms O'Neill's amendment to Mr Martin's amendment? Carried.

Anyone wish to speak to Mr Martin's motion, as amended? No questions? All in favour? Carried.

Shall section 1 carry as amended? Carried.

Section 2.

**Mr Martin:** I move that section 2 of the bill be struck out and the following substituted:

"2. Section 29 of the act is repealed and the following substituted:

"Disclosure to registrar of adoption information

"29. The registrar general may disclose personal information to the registrar of adoption information for the purposes of part VII of the Child and Family Services Act.

"Unsealing file

"29.1 The registrar general may, for the purposes of subsection 28(6) and section 29 and for such administrative purposes as he or she considers appropriate, unseal any file that was sealed under this act or a predecessor of this act."

**The Vice-Chair:** Any explanation? Any questions? No questions. All in favour? No opposition. Carried.

Shall section 2 carry as amended? All in favour? Opposed? Carried.

Section 3.

**Mr Martin:** It is recommended that the members vote against section 3 of the bill.

**The Vice-Chair:** Any questions?

**Mr Martin:** Now that we're changing this, this is no longer relevant.

**The Vice-Chair:** You've been asked to vote against section 3. All in favour of section 3? Opposed? Section 3 is lost.

**Mr Martin:** It is recommended that the members vote against section 4 of the bill. Same reason.

**The Vice-Chair:** It is recommended you vote against section 4. All in favour of section 4? Opposed? Lost.

**Mr Martin:** It's recommended that the members vote against section 5 of the bill. Same reason.

1740

**The Vice-Chair:** It is recommended that you vote against section 5. Did you have a question, Mrs O'Neill?

**Mrs O'Neill:** I just wanted to ask—this is such a different way of doing things—are all of those sections now incorporated? Is that what we're really being told?

**Mr Martin:** Yes.

**Mrs O'Neill:** They're all being incorporated in other sections. So the bill is literally going to have fewer sections.

**Mr Martin:** Yes.

**The Vice-Chair:** All in favour of section 5? Opposed? Section 5 is lost.

**Mr Jackson:** It's refreshing to see a government motion framed this way and seeing them all vote that way.

**The Vice-Chair:** Section 6.

**Mr Martin:** I move that section 6 of the bill be struck out and the following substituted:

"6. Clause 60(u) of the act is repealed."

**The Vice-Chair:** Any questions? All in favour of Mr Martin's motion? Opposed? Carried.

Shall section 6, as amended, carry? Carried.

Section 7.

**Mr Martin:** I move that clause 163(2)(b) of the Child and Family Services Act, as set out in section 7 of the bill, be struck out and the following substituted:

"(b) ensure that counselling is made available to persons,

"(i) who receive identifying or non-identifying information from the registrar,

"(ii) who are or may wish to be named in the register,

"(iii) who are concerned that they may be affected by the disclosure of identifying information, including the disclosure of information under subsection 28(6) of the Vital Statistics Act, or

"(iv) who receive information under subsection 28(8) of the Vital Statistics Act;

"(c) receive and deal with notices and withdrawals of notices filed under section 165.1."

**The Vice-Chair:** Discussion?

**Mr Hope:** Could I just ask legislative counsel this question: With this amendment being put forward, specifically with subsections 28(6) and 28(8), would

28(9) be appropriate for this section or is it relevant to be there as far as counselling services being available?

**Ms Cornelia Schuh:** I don't think it's necessary to mention (9), because people will not be receiving information under (9) independently, only along with the copy of the no-contact notice they could receive under (8). So no, I don't think it's necessary to refer to 28(9) here in this counselling material.

**Mr Hope:** Even though it may deal with medical information? I'm asking really a legal question. We don't want to exclude somebody who's received medical information and may need counselling. I want to make sure that we're covered properly.

**Ms Schuh:** I think you are covered, because the person who gets information under (9) will always have received information under (8). You can't get information under (9) without getting it under (8).

**Mr Hope:** Okay. Thank you.

**The Vice-Chair:** Anyone else? Shall Mr Martin's motion amending section 7 carry? Carried.

Shall section 7, as amended, carry? Carried.  
Section 8.

**Mr Martin:** I move that clause 165(2)(j) of the Child and Family Services Act, as set out in section 8 of the bill, be struck out and the following substituted:

"(j) the disclosure of information for the purposes of section 165.1;

"(k) the disclosure of information for the purposes of prosecutions under section 176.1."

**The Vice-Chair:** Shall Mr Martin's motion amending section 8 carry? Carried.

Shall section 8, as amended, carry? Carried.

**Mr Martin:** do you have a further amendment?

**Mr Martin:** Is there a Liberal motion here at this point?

**The Vice-Chair:** Yes, there is. The next one, I believe. It amends yours, so would you proceed with yours first.

**Mr Martin:** I move that the bill be amended by adding the following section:

"8.1 The act is amended by adding the following section:

**"NO-CONTACT NOTICES**

"Definition

"165.1(1) In this section, 'birth parent' means a person whose name appears on an original birth registration as parent.

"Notice, birth parent's wish not to be contacted

"(2) A birth parent who wishes not to be contacted by the person named as his or her child in the original birth registration may file written notice of the wish with the registrar.

"Disclosure to registrar general

"(3) The registrar shall disclose the notice or the information contained in it, together with any other information provided by the birth parent, to the registrar general under the Vital Statistics Act.

"Non-application of subsections 2(2) to (4) of Vital Statistics Act

"(4) Subsections 2(2) to (4) of the Vital Statistics Act do not apply to anything disclosed under subsection (3).

"Effective notice

"(5) The notice becomes effective for the purposes of subsection 28(8) of the Vital Statistics Act when the registrar general has matched it with the original birth registration and completed the match.

"Ineffective notice

"(6) The notice does not become effective if, before the notice is matched with the original birth registration, the registrar general has already issued a copy of the original birth registration under subsection 28(6) of the Vital Statistics Act.

"Communication re outcome

"(7) When a notice becomes effective, or when the registrar general becomes aware that it is ineffective, he or she shall advise the registrar of the fact.

"Withdrawal of notice

"(8) A birth parent who files a notice under subsection (2) may withdraw it at any time, in writing.

"Effect of withdrawal

"(9) A birth parent who has withdrawn a notice under subsection (8) is not entitled to file a further notice under subsection (2) in respect of the same original birth registration.

"Privacy

"(10) For purposes of subsection 165(5), a notice or withdrawal of a notice under this section and the information it contains, and all other information dealt with under this section or generated in connection with its administration, constitute information relating to an adoption.

"Forms

"(11) The registrar may provide for and require the use of forms under this section."

**The Chair:** Thank you. There is an amendment to the government motion, so we will deal first with that amendment and then come back to the main motion.

**Mrs O'Neill:** Before I begin with the amendment, and these amendments have just changed the bill so much in its format, is this the section we're dealing with that has something to say about the one-year wait?

**Mr Martin:** No.

**Mrs O'Neill:** It's another section? Thank you. I'm just trying to clarify some of this in my mind.

**1750**

I move that Mr Martin's motion adding section 8.1 to the bill be amended by striking out subsection 165.1(3) of the Child and Family Services Act and substituting the following:

"Reasons

"(3) If possible, the birth parent shall provide, together with the notice, a written statement of his or her reasons for not wishing to be contacted.

"Medical information

"(3.1) If possible, the birth parent shall provide,

together with the notice, a written statement that briefly summarizes any information he or she may have about,

“(a) any genetic conditions that he or she has, and any past and present serious illnesses;

“(b) any genetic conditions and past and present serious illnesses of his or her own parents, of the other birth parent (or of the other biological parent, if only one person’s name appears on the original birth registration as parent) and of his or her parents; and

“(c) the cause of death and age of death of any of the persons named in clause (b) who are no longer alive.

“Disclosure to registrar general

“(3.2) The registrar shall disclose the notice or the information contained in it, together with any other information provided by the birth parent under subsection (3) or (3.1), to the registrar general under the Vital Statistics Act.”

This ties directly with the amendment I brought and the committee accepted earlier. The legislative counsel, if any are questioning, has presented me—and I don’t know whether all members have—the reason to have to place “birth parent” or “biological parent,” and that of course really directly relates to a father who may or may not be named.

**The Chair:** Any discussion of Ms O’Neill’s amendment?

**Mr Martin:** I’d just like the ministry folks to comment on it and share with us any concern they might have.

**Ms Belford:** I will ask my colleague John Calcott to comment on the wording of the amendment from a policy point of view. I don’t have any problem with the intention that is generated here. There are a couple of things that appear to me to be administratively difficult. One is determining if something is possible or not possible. It might be better to just be permissive, “The birth parent may provide.”

However, on the information that is requested here, what I generally find is that when we name very specific information, we sometimes limit other information that may be provided that would be useful and it may also be information—it does say, “If possible, the birth parent shall provide” it, but a lot of this may be information that they don’t know.

I think we could handle this by designing the form with certain questions on it, prompts on it that would ask them to provide any medical information that might be useful to the adoptee. One of the things that some of the people asked for in the presentations was information about who they might look like or what their physical characteristics were, so there’s an infinite variety of things that could be named here.

We’re certainly willing to pass on anything that the birth parent is willing to share, and from a policy point of view we have no problem in doing that. We’re willing to deal with anything that the committee decides is relevant. I just would warn against limiting what might be here.

**The Chair:** If you can hold on to that thought, Ms

Gigantes had a point and then we’ll come back and look at—

**Ms Gigantes:** I was going to ask Ms Schuh if our adoption of the first Liberal amendment does not give legislative authority for the setting of regulations about the form that will be used when a birth parent files a no-contact notice. In other words, having adopted—

**Ms Schuh:** Not exactly. Mr Martin’s amendment that’s before the committee, adding section 165.1, provides in its last subsection that, “The registrar may provide for and require the use of forms....” Those would not be made by regulation. Those would be made administratively and could be changed more easily.

**Ms Gigantes:** Maybe I haven’t asked my question right. Let me try again.

We’ve adopted the earlier motion put forward by Ms O’Neill which says that the registrar shall give to the inquiring person, the adopted person, any information that was filed under the Child and Family Services Act together with the notice. So that presumes a notice, it presumes that there is information on some kind of form, it presumes that there is a form available on which to provide the attached information, which would be medical information. Would that not give authority to make a regulation authorizing the creation of a form to elicit medical information without specifying what kind of medical information?

**Ms Schuh:** No, I don’t think it would. I think if you wanted authority to do that by regulation, you would have to have specific words to that effect in the statute.

**Ms Gigantes:** Then can we amend the amendment which has been put forward by Ms O’Neill so that we’re not specifying too closely exactly what should be requested, but at the same time authorizing the creation of a form of the nature that we’ve just had described to us?

**Ms O’Neill:** May I speak? I discussed this quite extensively with legislative counsel because in the beginning there was—what should I say?—a presentation that talked about personal health. I didn’t think that I wanted to put that onus on any birth parent to talk about their personal health at the present time.

What I really want to do is be very specific with what I thought I had heard from the presentations, genetic illness, and if I may use a very personal example, both my grandparents, both my grandmothers, died with diabetes. That now is something people check medically with me all the time. My mother and her sister both died with heart attacks. That’s the kind of thing.

I know it would be nice to know whether your mother had brown eyes or not. I don’t think that’s important. Those are nice to know. These to me are things like people were suggesting yesterday. When you go to apply for extended medical coverage or you go to apply for an insurance policy, you can’t fill in any of these. Even with your own family doctor, you can’t talk about serious illnesses in your family. I felt the genetic is one thing and serious illness is another thing, and that’s the reason I put those two.

It was legislative counsel’s wish, and maybe my own

personal experience led me to be very accepting of it, to go beyond to the next generation, to the grandparents, because in many cases that's also very relevant. Some of these diseases skip a generation.

I'm not tied to (c), which is the cause of death, but again it could be quite relevant. If again I use my example of sudden death by heart attack, then you need to kind of know that. That's my intention.

**The Chair:** May I, with the intention of trying to help us through this, because I sense that both Ms Gigantes's comment and also from the ministry were intended to be helpful in dealing with this—

**Ms Gigantes:** Helpful. That's right.

**The Chair:** As the Chair, we cannot have an amendment to the amendment to the main amendment. However, we could still step back and seek an amendment that we're all comfortable with. In order to do that, we can either just have a brief recess to try to sort that out and it would then require Ms O'Neill withdrawing her amendment so we could bring in a new amendment that we agreed with, or we could stand this down and proceed with other parts of the bill and come back. We can continue the discussion, but at some point, in terms of making any change, I can't accept an amendment to the amendment to the amendment directly.

1800

**Mrs O'Neill:** Could we get the ministry officials to reiterate what—you say it could be limiting. Anything can be limiting, and that's partly what this legislation is about, I suppose, is limiting, especially if we're talking about non-contact parents.

As I say, there's a group of stuff that's nice to know. This I think is important to know if it's at all possible. This act is going to be administered by several different people in the next, whatever, 40, 50 years. I thought it would be nice for them to know the kinds of questions that the presenters in 1994 brought to us as real problems for them.

**The Chair:** Just before I got to the ministry officials, Mr Hope and Ms Gigantes. That way, we can get everything on to the table.

**Mr Hope:** I was trying to be specific in the legislation. I guess my concern is that science changes and health changes; so does the information provided. I was listening to the people from the ministry dealing with it's not a problem to administer. There could be some legal questions.

I'm wondering if it was just referred to as per the disclosure to the registrar general, that something be as prescribed by regulation, which allows us then to move on and so that we're not coming back 10 years from now and saying, "Okay, we've discovered a new disease" or "Something else has come up" or "Modern medicine has discovered something," but instead of dealing with the amendment that Mrs O'Neill has put forward to Mr Martin's motion, that we just put an amendment forward dealing with disclosure to the registrar general, a content of regulation, which allows us the drafting of a document which can be changed but can be current to the information required at times.

I approached this on some of the comments that I heard, raising that administratively—and there could be other problems. I'm saying we need to move on. It's going to be a while before this thing is implemented. Let's then look at a regulation which would develop the clear policy that we need to do around health disclosure information that's required or medical information that's required.

**Ms Gigantes:** I tend to agree with Randy's proposal, and if I could, without breaching the Chair's outline of the rules on which we're proceeding, perhaps if we took items (3) and (3.1) and phrased them, "birth parent shall be invited to provide."

**The Chair:** The Chair is always willing to accept suggestions. It's just that if this is agreed on, we'll need to then withdraw one amendment and bring another. I'm quite willing to let us try to sort this through, and so as long as people would like to do that, we can continue that way, or we can stop and try to just—

**Mr Hope:** Ask for a few minutes' recess.

**The Chair:** Have a few minutes' recess if that will help. But I would like to let the ministry officials just complete their comments and then we can see how we'd like to deal with that.

**Ms Belford:** I think from a policy and administrative point of view, we would be willing to collect any information that will be genuinely helpful to the adoptee and that the birth parent is willing to provide. We do have to, I think, keep in mind that we have limited resources and we don't want to get into the backlog problem again by making it so onerous that it's going to take somebody a very long time to complete the information.

We're willing to try to accommodate anything that the committee believes is important. I would like my colleague John Calcott, though, from legal services to comment on the wording, perhaps.

**Mr John Calcott:** Just to reiterate, I guess, Joan's concern about the phrase "If possible, the birth parent shall provide," I think it does cause us a little bit of concern that maybe it will be read as though the filing of a no-contact wish will be contingent upon them actually providing some information. As Joan indicated, there may be some concern about, what type of proof then would we require? Would we take someone's word for it if they said, "My grandparents died when they were 56," or do we say, "Prove it to us"? To what extent are we going to then be required to ensure that the information is accurate?

Again, stepping back, in Mr Martin's motion in subsection 165.1(3) it says there that the registrar shall disclose the notice or the information contained in it, together with any other information provided by the birth parent. I think the intent there was to be as broad as possible, and that is where we would include the reasons, if any were given, why no contact is requested.

We had some discussion when we saw the Liberal motion as to whether or not that would be broad enough to include medical information as well, and there is some debate as to whether it would or it wouldn't. I think a lot would depend on how you design the form. It may be

broad enough to read it that it would include medical information. Even if it wasn't, the Child and Family Services Act does have a mechanism to receive non-identifying information. I can appreciate, though, that there is delay in getting that information, as we've heard from other people. There is another mechanism to deal with disclosing other non-identifying information.

**The Chair:** If I might suggest that there seems to be the possibility of perhaps coming up with some wording that would be acceptable, perhaps I could call for a short recess so that legislative counsel, ministry staff and Mrs O'Neill could—

**Mrs O'Neill:** Before we do that, I'd like to ask—and that may not be necessary. I'm happy enough with Ms Gigantes's suggestion. I don't know whether what Mr Hope has suggested is possible. Legislative counsel has twice suggested that regulations don't fit here.

I would certainly be willing, if it would make it any better—and I do want to make it very clear that I'm not going to grandparents. I'm going to grandparents, it's true, of the adoptee, but not to another generation. So I would be very willing to put "be invited to provide" if that makes the whole world easier for everybody.

I really do believe that what we said earlier—and I can certainly understand the ministry's concern about workload. But if this bill is going to be meaningful, it's got to have some bucks. If we're not going to provide this kind of information, which is crucial to a person's life, because I'm talking about life and death here, and especially when you're talking about children of children—the adoptees are very concerned about having children. I've had this in my office. I've had it here. It's a very big concern to them. So if they had this information, if at all possible, then that should be, in my mind, a priority on the file.

**The Chair:** I think it is our intent to try to see if we can get that wording. Just before we do, Mr McGuinty and Mr Martin have both indicated they want to speak. If we could keep that brief, I think it probably is in everybody's interest that we have a recess just to make sure we get the wording right.

**Mr McGuinty:** I just want to ask ministry counsel: I'm not sure if I really understood the full import of what he was saying.

**Ms Gigantes:** That's what they're paid for.

**Mr McGuinty:** Yes. Are you saying essentially that this amendment is not necessary because that power or that authority is contained within existing statutes? Is that what you're telling us?

**Mr Calcott:** That's the way that I read it, yes.

**Ms Gigantes:** To make the form, that is.

**Mr Calcott:** Not so much to make the form, but for them to provide the information, yes, and we would then prescribe the form. I suppose administratively, rather than have a blank section and have people write in their medical history, there could be prompts in there if we deem it appropriate to use the form as the mechanism to do this. But if that's not appropriate there are other ways to share non-identifying information through the Child and Family Services Act.

**Ms Gigantes:** I think the problem is that Mrs O'Neill is interested in having the legislation indicate our desire to do that, and that's why we need to take a run at it.

**Mrs O'Neill:** Yes, and I think legal counsel has given me very good advice, which I want to follow.

**The Chair:** Could I suggest that we just take a brief recess, and legislative counsel, ministry officials, Ms O'Neill and anyone else could just come together. For everyone's information, in case somebody's just going to step outside, it's 10 after 6. Could we say 6:20, 10 minutes? If we need more we'll take more, but let's see what we can accomplish in 10 minutes.

The committee stands adjourned until 6:20.

*The committee recessed from 1810 to 1857.*

**The Chair:** The standing committee on social development is now back in session. The clerk is just handing out the new amendment. I just want to let everybody get it in front of him or her.

**Mr Norm Jamison (Norfolk):** Do we have it translated yet?

**The Chair:** We will need to do a couple of things. I think perhaps what I will do, if it's agreeable to the committee, is ask legislative counsel if she would be kind enough just to walk us through it.

**Mr Hope:** First of all, we should read it in.

**The Chair:** Yes, first of all to read it in, and then if you could just walk us through it and if there are any questions, and then I realize that we'll have to go back and reopen section 1 of the bill, but if you would be good enough to do that.

**Mr Hope:** Before she interprets, I would ask that the motion be read into the record by Mrs O'Neill. It's her amendment, so she would have to read it into the record.

**The Chair:** Well, the only thing is that Mrs O'Neill will have to withdraw her original amendment so that we can then read this one into the record.

**Mrs O'Neill:** I won't have to read it, though, will I, Mr Chairman?

**The Chair:** Do you want to do that?

**Mrs O'Neill:** Will I not be able to just say that I, at this time, would like to withdraw the amendment that I formally presented regarding "Reasons," subsection (3), "Medical information," subsection (3.1) and "Disclosure to registrar general," subsection (3.2)?

**The Chair:** That's fine. Would you then read the new amendment for the record.

**Mrs O'Neill:** I would like to place the following amendment in its place:

I move that Mr Martin's motion adding section 8.1 to the bill be amending by striking out subsection—

**The Chair:** Excuse me. Could I just ask if you could read the part just above, because there are a couple of wording changes, just to make sure that we have the full amendment.

**Mrs O'Neill:** Okay. I hope I can interpret the handwriting.

**The Chair:** We will assist, if necessary.

**Mrs O'Neill:** Section 8.1 of the bill, subsections

165.1(3) and (3.1) of the Child and Family Services Act.

I move that Mr Martin's motion adding section 8.1 to the bill be amended by striking out subsection 165.1(3) of the Child and Family Services Act and by substituting the following:

"Other information

"The birth parent shall be given an opportunity to provide, together with the notice,

"(a) a written statement of his or her reasons for not wishing to be contacted;

"(b) a written statement that briefly summarizes any information he or she may have about,

"(i) any genetic conditions that he or she has, and any past and present serious illnesses;

"(ii) any genetic conditions and past and present serious illnesses of his or her own parents, of the other birth parent (or of the other biological parent, if only one person's name appears on the original birth registration as parent) and of his or her parents;

"(iii) the cause of death and age at death of any of the persons named in clause (b) who are no longer alive; and

"(iv) any other health-related matters that may be relevant;

"(c) a written statement of any other information that may be relevant."

That is my amendment as I now present it.

**The Chair:** There's still the last part.

**Mrs O'Neill:** "Disclosure to registrar general," which now is numbered as (3.1).

"(3.1) The registrar shall disclose the notice or the information contained in it, together with any other information provided by the birth parent, to the registrar general under the Vital Statistics Act."

**The Chair:** There will be another amendment, but we will deal with this one first. Okay? Any discussion?

**Mr Hope:** Just a correction to the record. At the start of the reading of the amendment, (3) was not indicated as part of it. We just started with "Other information." It never went into specifying the section.

**The Chair:** Okay. If members are comfortable, then I would put the amendment. All those in favour? Opposed? Carried.

I believe we will have to, then, deal with Mr Martin's amendment, because we have just passed the amendment to Mr Martin's amendment. We'll deal with that, and then we will go back and open section 1.

Mr Martin, you've already read that into the record.

**Mr Martin:** I have a slight amendment that I need to make to that as well, given what we've just done to subsection (3.1). Do I have to go through the whole thing?

**The Chair:** It's probably best.

**Mr Martin:** Okay. I withdraw my previous amendment.

**The Chair:** You may not have to do this. You can just indicate to us the amendment you wish to make to yours. You don't have to read the whole thing.

**Mr Martin:** Three quarters of the way down the page, "Non-application of subss. 2(2) to (4)."

**Mrs O'Neill:** What page are you on?

**Mr Martin:** I'm on page 3-CS. It's section 8.1 of the bill, section 165.1 of the act. I want to add to that section there.

**The Chair:** After "under subsection (3)"?

**Mr Martin:** Yes.

**The Chair:** Okay, perhaps Mr Martin, if you could read that part.

**Mr Martin:** I'll read that, yes.

"Non-application of subss. 2(2) to (4) of Vital Statistics Act

"(4) Subsections 2(2) to (4) of the Vital Statistics Act do not apply to anything disclosed under subsections (3) and (3.1)."

**Mr Hope:** A comment. I would ask for the legal interpretation, because we'll be dealing with the amendment to the main motion. I'm asking for legal interpretation of the changes that we made to Mrs O'Neill's. Our legal counsel knows that specifically what I'm talking about is the interpretation of "information provided."

**The Chair:** Okay, I'll call on legislative counsel.

**Ms Schuh:** I'm very sorry to break in here and confess that in my haste I made a mistake here in accepting a suggestion that we needed to add the reference to subsection (3.1). I'm sorry. The reference to subsection (3), at the end of subsection 165.1(4), the subsection with the side note "Non-application of" etc, that reference to subsection (3) is subsection (3) just up above, subsection (3) of the same section.

**The Chair:** So we can leave it then? We don't need to make the change?

**Ms Schuh:** Yes. I'm sorry. I beg the indulgence of this committee. It was a mistake.

**The Chair:** I hate to say, "Ignore what Mr Martin has just said," but—

**Mr Martin:** Cross that off the record.

**Ms Schuh:** It never happened.

**The Chair:** So we are dealing with Mr Martin's amendment as it was originally put forward, but before we do that, Mr Hope.

**Mr Hope:** I wanted to ask legal counsel to explain for the record, because it could lead to information being provided from the data collected; it could reveal more than what was required. I want to make sure that "(c) a written statement of any other information that may be relevant" is not so broad that it leaves open the addresses and other things of people providing the information.

**Ms Schuh:** Actually, if the birth parent wanted to provide an address here, nothing would prevent the birth parent from doing it. It would be a senseless thing for the birth parent to do, given that this is a document that's being provided in connection with a no-contact notice, but I don't think there are any restrictions on what information the birth parent could provide under clause (c).

**Mr Hope:** The information with the person's name on

the top of it, if it's not written by the individual, then it cannot be revealed? I'm mailing an information form out to somebody I know is the birth parent, with an address and everything else. The written statement that comes back on the provided form, that top information is not part of the revealed information. Do you follow what I'm saying?

**Ms Schuh:** I think that probably ministry legal staff would be best placed to respond to that.

**Mr Calcott:** I think what would be intended there is that you have to separate out the information on their application to register the no-contact notice from other information that they may wish to attach to that no-contact notice. The way we would operationalize that is that we would make it clear, when they fill out their application form, that (c) is a separate written statement that they themselves fill out, so that their name and address, which form part of the application form, aren't part of either (a), (b) or (c).

**Ms Gigantes:** Can I suggest that we might achieve what we're looking for here by saying in (c), "a written statement of any other non-identifying information that may be relevant."

**The Chair:** "A written statement of any other non-identifying information that may be relevant." So adding the word, "non-identifying."

**Mr Hope:** It's okay the way it's written. I just needed the lawyers to put on the record what this meant.

**Ms Gigantes:** The problem is that the lawyers may know what it means, but does the person who helps fill out the form or receives the material know what it means? I know lawyers hate repetition when it's redundant, but sometimes repetition helps in administrative issues.

**Mrs O'Neill:** We have got a little problem. I think we've passed my amendment. So if we're going to add words, I think we're going to have to have it read again.

**Mr Hope:** I wanted an opinion on the definition, because you notice I dealt with it as a whole motion versus just the amendment. What I wanted was an opinion.

**Ms Gigantes:** I'm going to move that we amend clause (c) of what we've just accepted to read, "a written statement of any other non-identifying information that may be relevant."

1910

**The Chair:** I'm quite prepared to go back to what we've passed if people are agreeable.

**Mr Jackson:** Unanimous consent agreed?

**The Chair:** Is there unanimous consent? Okay. So we would reopen Mrs O'Neill's amendment. Under (c) it would read, with the amendment:

"(c) a written statement of any other non-identifying information that may be relevant."

**Mr Jackson:** You can't move this.

**The Chair:** No, I can't. Would you be good enough to move it?

**Ms Gigantes:** I would so move.

**The Chair:** All those in favour of the amendment? Opposed? Carried.

We'll now move to Mr Martin's amendment, as amended.

**Mrs O'Neill:** I thought we didn't have to amend it.

**The Chair:** Your amendment amends it. I sometimes wonder, you know, people watching us do clause-by-clause, whether they feel we're in another world. Can we just hold? It is important we get this right. Just pause for a moment. We want to make sure that we get this right. Legislative counsel, please go ahead.

**Ms Schuh:** I'm sorry to say that I've made a further mistake. In fact, the addition of the reference to subsection (3.1) in subsection 165.1(4) was correct. I think you can all appreciate that this is a very confusing process, but Nancy Sills, the lawyer from Consumer and Commercial Relations, has pointed out to me that it should indeed be added, and I think she's right. I do apologize. I can only say that this is all happening very quickly.

**The Chair:** We quite understand. Don't apologize. It's important we get this right. If we have to amend and reamend and amend again to get it right, we will.

Let me just back up then. First of all, we are now agreed on Mrs O'Neill's amendment, and we have carried that.

We have now moved to Mr Martin's amendment. I think just to be safe, can you just go back to our favourite non-application clause?

**Mr Martin:** You mean subsection 165.1(4)?

**The Chair:** Right. If you'd just read that back in.

**Mr Martin:** "Subsections 2(2) to (4) of the Vital Statistics Act do not apply to anything disclosed under subsections (3) and (3.1)."

**The Chair:** All those in favour of Mr Martin's amendment, as amended? All those opposed? Carried.

**Mr Hope:** It's a good thing this is not a partisan bill.

**The Chair:** I now would ask that we carry section 8.1, as amended. All in favour? Opposed? Carried.

I'll now call section 9. All those in favour? Opposed? Carried.

We then come to section 9.1.

**Mr Martin:** There are a couple of changes here to even the amendment that you have, that legislative counsel has brought to my attention. I'll explain that in a minute.

I move that the bill be amended by adding the following section:

"9.1 The act is amended by adding the following section:

"Offence, contacting birth parent despite notice

"176.1 (1) No person who has been given information under subsection 28(8) of the Vital Statistics Act together with a copy of his or her original birth registration shall knowingly contact or attempt to contact the birth parent, directly or indirectly, except under section 167 or 169."

**The Chair:** Say that again, please.

**Mr Martin:** "Except under section 167 or 169."

**The Chair:** "Except under section 167 or 169." Does everybody have that? We'll ask you just to tell us what that means.

**Mr Martin:** Okay, this is coming at you again, so I'll wait until the end and then I'll tell you, okay?

"Same

"(2) No person shall knowingly contact or attempt to contact the birth parent, directly or indirectly, on behalf of another person who is prohibited from doing so by subsection (1), except under section 167 or 169."

**The Chair:** Okay, "except under section 167 or 169."

**Mrs O'Neill:** Mr Chairman, could we just hear what—

**The Chair:** We're just going to let him finish all the amendments and then we'll go back.

**Mr Martin:** The next is:

"Same

"(3) A person who contravenes subsection (1) or (2) is guilty of an offence and on conviction is liable to a fine of not more than \$5,000."

Without these added words, an adoptee who applies under those sections to the adoption disclosure register for a search by the registrar would be contravening this section and committing an offence.

**The Chair:** That was all to be added after "\$5,000"?

**Mr Martin:** No, that's just the explanation.

**The Chair:** Oh, sorry. Let's just get the additional words straight first. The additional words are just "except under section 167 or 169."

**Mr Martin:** Yes. What we're saying here is without these added words, an adoptee who applies under those sections would be contravening this section and committing an offence.

**The Chair:** We'll now have discussion. I have Mr Hope and Ms O'Neill.

**Mr Hope:** First of all, I don't have the full context of 167 or 169 and I would ask those who have that information if they could read it aloud so we know what those specific sections make reference to. You're exempting sections 167 and 169, and I don't have the total 167 or 169 in front of me to make an honest judgement call about an amendment we're being asked to support. Could I ask ministry counsel?

**Mr Calcott:** Section 167 of the Child and Family Services Act is the section that permits, among others, adopted persons who have attained 18 years of age to apply to be registered in the adoption disclosure register. Once our ministry receives an application, we're required to register the name in the register and then conduct a search of the register to see whether there's been a match.

**Ms Gigantes:** That would be an indirect contact.

**Mr Calcott:** I guess there's some concern that that may be an indirect contact, if someone applies to register the name.

Similarly, section 169 of the Child and Family Services Act permits an adopted person who has attained the age of 18 years to request a search for, for example, a birth parent, and we want to make it clear that that wouldn't be

considered to be contravening the legislation as well. Once they enter into the adoption disclosure register, it is a consensual register and identifying information isn't shared until both parties agree.

**Mrs O'Neill:** When that happens, this bill kicks in and they would be told there is a request for no contact.

**Mr Calcott:** Pardon me? I didn't understand.

**Mrs O'Neill:** They wouldn't be committing an offence, but the information would be relayed to them at that time that there has been a no-contact registered.

**Mr Calcott:** The information will be relayed to them when they receive the copy of the original birth registration. But let's say a couple of months later they decided to apply to the Community and Social Services adoption disclosure register on the off chance perhaps that their birth parent had changed his or her mind and entered into the register, that wouldn't be viewed, if there was a no-contact notice there that hadn't been withdrawn, as breaching the law.

**Mrs O'Neill:** I hate to ask this question, but we're trying to be thorough. You're suggesting to me now, and I've been thinking about this as well, that you've got the two registers. Is there any chance that they would ever be in conflict, the birth parents who are suggesting that they want to be found and would be part of a consensual and that there would be also a no-contact with the same person? Or will these be automatically cross-checked at all times?

Some people have a great deal of difficulty making a decision on this matter, may be wanting to do one thing to please a certain circumstance, do another thing to please another circumstance, and I presume this is an administrative matter, but I guess we need to know, would there ever be a possibility for a conflict between these two lists or registers?

**Mr Calcott:** I suppose, theoretically, it is possible that someone could register a no-contact wish and then enter into the adoption disclosure register. I guess it's a bit illogical that one would do that. If you wanted to move to a reunion, to sign up on the adoption disclosure register, you would most likely use the provision in Bill 158 to withdraw your no-contact notice.

1920

I suppose there is a situation where perhaps if you forgot or you didn't withdraw it and it was sort of sitting there, but I think, and maybe Joan can speak to this, that's perhaps one of the things, administratively, that we would ask people, "Have you registered and, if so, have you withdrawn your registration?" If you move to the offence provision, I think it's unlikely that any prosecution would be successful if the person encouraged contact through the adoption disclosure register and then subsequently said, "Hey, you violated the no-contact."

**Mrs O'Neill:** Okay, and if Joan wants to make a comment, it would be fine.

**Ms Belford:** That's fine.

**The Chair:** All right. Is everyone comfortable then?

All those in favour of Mr Martin's amendment, as amended? All those opposed? Carried.

We then come to section 10, and just to remind everyone, I will go back to section 1, because we have that one that we have to go back to at the end. Mr Martin, section 10.

**Mr Martin:** Did we pass section 9.1?

**The Chair:** Yes.

**Mr Martin:** We did? Okay.

I move that subsection 10(2) of the bill be struck out and the following substituted:

“Same

“(2) Section 1, subsection 9(2) and section 9.1 come into force on the first anniversary of the day named by proclamation.”

**The Chair:** Any discussion? Mr McGuinty.

**Mr McGuinty:** I have some comments of a general nature, but maybe now's as good a time as any to make them, as we wind up, and I've made reference to these earlier. My concern is that what we're doing is advancing the rights of the adoptees at the expense of the birth parents. I just want us to recognize that that's happening and that, to repeat, this legislation goes further, in my understanding, than any other legislation anywhere in terms of giving adoptees the right to obtain birth particulars without involving the birth parents in that decision.

I want to again just emphasize what the Information and Privacy Commissioner said in his letter to us: “However, unlike the present Child and Family Services Act, the bill does not provide birth parents with an opportunity to express their views on access to identifying information about themselves. In other words, under the bill”—this bill that is—“adoptees' rights outweigh birth parents' privacy rights in all cases, without exception.”

There's no doubt that people are contacting their birth parents now, but I think the important change for us to understand is that they've not been doing so with the assistance of the province. Now the province will be providing birth particulars.

The real concern I have is the presumption that is created in the bill that says you are presumed to desire contact. If you don't register a no-contact notice, you are presumed to desire contact. I would have felt more comfortable, and I don't think it changes very much, if we had a different presumption in there, and that presumption would be that the desire is for no contact unless you register.

I think the objective of the bill is to provide birth particulars. That doesn't change it. They're going to get the birth particulars either way. The only difference that I think would have lent greater weight to the birth parents' right to confidentiality would be created through that presumption of no contact. What we're going to have now is we're going to have some people contacted who don't want to be contacted. Again, that's happening now but never before has it happened with the assistance of the province.

I understand that if you don't want to be contacted and you are contacted, that can be a fairly disruptive experience, and I think we could have done something here

today which would have made it a little harder for that kind of corollary damage to occur. Anyway, I just wanted to put that on the record and make it clear that there are some downsides to this legislation—like anything else, it's not all good—but I think we could have tightened it up a little bit to better recognize and give life to the right of a birth parent to confidentiality.

**Ms Gigantes:** I think we recognize what is at issue here and we have to make a decision. That's what the bill is about. I don't think there is any little thing that we can do that will achieve the main purpose of what we want to achieve here, without making the decision that in fact we are saying it is more important for adopted people to have access to information about themselves. It's also their personal information. It's not just the parents' information—

**Mr McGuinty:** That's not the issue. I agree with that.

**Ms Gigantes:** —it's also their information. If any of us could think of a way of providing them with that information without disclosing somebody else's information if they didn't wish to have it disclosed, that's what we'd choose to do, but there is no possibility of doing that.

**The Chair:** I appreciate concerns. We are dealing with an amendment which I would like to move. I know there are others who wanted to speak and I will permit that, but I would otherwise just move the amendment.

Mr O'Connor, then Mr Hope and Mrs O'Neill.

**Mr Larry O'Connor (Durham-York):** Just on the concern raised by my colleague Mr McGuinty, maybe in a way of trying to share information in the form of recommendation to the people from the ministry here, there are any number of different government cheques that are issued, and on the stub of that cheque, there is a spot where information could be shared and maybe that's one place in which the information could be shared. It doesn't cost a lot of money in a campaign and isn't necessarily going to hit every birth parent, but it has an opportunity of possibly hitting some birth parents. I think that the bill does reflect a change in attitude and position and I support it. I'm just trying to reassure my colleague there.

**Mr Hope:** Maybe we could keep it very short, because once I listened to Cam and he didn't even say anything. He just showed his hands. But what I would like to put on the record is, those individuals who are put up for adoption never had the opportunity of contact or say, and what they're asking for is the opportunity to be restored and that is important. I'll shut it off there.

1930

**Mrs O'Neill:** I just want to affirm that the adoption disclosure register, as we now know it, is going to be maintained, that is, that birth parents who do want to have reunification will still be able to register in this province. Is that correct?

**Ms Belford:** Yes.

**Mrs O'Neill:** I think that is important.

I wanted to ask Mr Martin, considering what was said today, particularly by the children's aid societies, if he had thought of changing from the one year, the first

anniversary. I don't know how much data has been collected about whether an information package and an education process across Ontario, let alone across Canada, can be achieved in one year. Let's be realistic. We're going to be in the middle of an election campaign, all of us, in that year. Have you thought about that at all?

**Mr Martin:** No, I hadn't. The suggestion of extending that time period, this is the first I've heard of it today. Given the strong feeling of the folks who are driving this piece of legislation, the adoptive community out there, I think a year is sufficient. I think they feel probably a year is even too long. If we're going to do this, let's do it. There will be a program of public education that will happen, election or no election. The folks who work for the government don't get themselves involved in those sorts of things and will be working while we're out there.

**Mr Jackson:** There are budget implications here.

**Mr Martin:** Yes.

**Mrs O'Neill:** That's important.

**Mr Martin:** That has been considered. We will be making sure in the ways we have to us that we will be communicating the changes that are happening here and trying in whatever way we can to let people know. I think Ms Gigantes earlier tonight said too that we could do this for two years, we could do it for five years, we could do it for 10 years, and they still wouldn't cotton on to what's happening because it just isn't something they're concerned about or looking into. So I'm comfortable that the year is enough.

**Mrs O'Neill:** I just want an affirmation. I'm sorry, but JobLink is an example of this government making announcements, then consulting and still no moneys flowing. I'm very concerned that if this goes until June, there will not be anything flowing in the way of information. We'll be tied to this and there are people who need to know about it. So I really hope the government will do this tout de suite.

**The Chair:** I'll put the question then. All those in favour? Opposed? Carried.

All in favour of section 10 as amended? Opposed? Carried.

Before going to section 11, I'd like to now go back to the amendment to section 1. Is unanimous consent granted? All right. If you would bear with me, I'm going to read it, because there are a few other words that have to be added to this. It would now read as follows:

"Section 1 of the bill (subsection 28(9) of the Vital Statistics Act)

"(Other information

"(9) The registrar general shall also give the adopted person any information provided by the birth parent under subsection 165.1(3) of the Child and Family Services Act and disclosed to the registrar general together with the notice; if no such information was disclosed, the registrar general shall advise the adopted person of that fact."

Legislative counsel, for the benefit of members, just why the change in that wording?

**Mrs O'Neill:** Mr Chairman, I'm using the same process. I'm not withdrawing and submitting a new one, because that's still sitting there.

**The Chair:** I'm sorry. You're right. We have to pass this first and then you withdraw yours. No, passing this, I'm informed, will in effect supersede what you have already done.

**Mrs O'Neill:** I leave it in the hands of the experts. I did one thing one time; I thought I was going to do it again.

**The Chair:** Legislative counsel, could you comment?

**Ms Schuh:** We've changed the side note and the reference to provisions of 165.1 to parallel the changes that we made to Mrs O'Neill's motion adding various subsections to 165.1. In the redrafting that we did during the recess, we collapsed (3) and (3.1) into a single subsection (3). So that's all we need to refer to here.

**The Chair:** All right. The first thing is, then, shall Mr Hope's motion carry? Carried.

Shall section 1 of the bill, as amended, carry? Carried.

We then go back to section 11. Shall section 11 of the bill carry? Carried.

Shall Bill 158, as amended, carry? Carried.

Shall the bill be reported to the House? Carried.

Before everyone goes, first of all, we have another matter we have to deal with, but with respect to this particular bill, I'd like to thank legislative counsel, the staff from both ministries, for working with us over the last couple of weeks, and in particular, if I might, all of those persons who came before the committee. This, I think I can say, has at times been a very emotional set of hearings and I just want to thank everyone who's been associated with this and also has helped us through the niceties of some of the wording for all their help.

I want to ask the clerk to circulate a letter which I received today and which I need to raise with the committee, which regards our future course of work.

**Mr Jackson:** Does it affect Bill 85?

**The Chair:** Yes, it does.

**Mr Jackson:** And you didn't give me a copy?

**The Chair:** We're just circulating it. We just received this letter late this afternoon. Members will recall that yesterday the subcommittee met and at the end of our session yesterday I advised members of the committee that the subcommittee had requested that I write to the government House leader with respect to Bill 85, and I did so. I'll just read the letter so it's on the record. It's addressed to me, and says:

"Thank you for your letter of 6 December about the subcommittee's request for intersession time. I understand the full social development committee was unable to discuss the subcommittee's report yesterday. I suggest the full committee discuss and vote on the subcommittee's request today as it is the last scheduled committee meeting of this session. I look forward to hearing from you in this matter.

"Yours sincerely,

"Brian Charlton, government House leader."

The subcommittee had met and it was on that basis that I had sent the letter. We have an opportunity for the full committee to discuss this matter and I would now like to make sure that members of the committee have an opportunity to discuss it.

**Mr Hope:** May I ask what the subcommittee report was?

**The Chair:** The subcommittee report was that the House leaders schedule time in the intercession for us to deal with Bill 85, which was the last remaining piece of legislation before our committee which we had not dealt with.

You may recall—or I'm not sure whether you were with the committee then—that in the spring we had planned to deal with that bill and then it had been decided we had to do long-term care and we would do the adoption bill, and we had not scheduled Bill 85, so that was brought back to our attention, once we had dealt with long-term care and with Bill 158.

1940

**Mr Hope:** Are you telling me that the subcommittee is recommending an unspecified time period to deal with one bill or just as specified to sit?

**The Chair:** The subcommittee was recommending that we find a week in January or February, excluding the last week in February, to deal with that bill. That was the wording. So, essentially, I guess Monday, Tuesday, Wednesday, Thursday would be—

*Interjection.*

**The Chair:** The end of February? Some members of the committee were not going to be here; that's why we put that in.

**Ms Gigantes:** Mr Chair, I'm not in favour of the subcommittee's report or recommendations.

*Interjections.*

**The Chair:** Order, please. I'm sorry. Could you repeat that? I just didn't hear.

**Ms Gigantes:** I'm not in favour of the subcommittee's recommendation. I don't think that we should be meeting in this committee in the intercession period and therefore I'm going to vote against the recommendation. The bill will be with us, can be carried over—

**Mr Jackson:** Do you know what the bill's about?

**Ms Gigantes:** Yes, I do.

**Mr Jackson:** What is it about?

**Ms Gigantes:** Mr Chair, if I could finish my remarks, this matter has been put before us in a private member's bill, which is a member's bill that reflects issues which have been raised in private members' bills, to my knowledge, for the last 15 years when Jim Renwick certainly tabled a private member's bill dealing with proceeds from crime. I would ask the committee members to agree that we will suggest to the House leaders that it be dealt with once the House has met again in the spring.

**The Chair:** Ms Gigantes, the letter that went forward was an advisory letter simply indicating to the House leaders what the subcommittee was suggesting. It was not a decision of the committee; it was advisory to them to determine whether to do that or not.

**Ms Gigantes:** Well, we're now being asked by the government House leader to discuss it, which I think is appropriate. A subcommittee doesn't report to the House leaders; it reports to this committee. I therefore indicate my preference on this matter and the reasons why.

**The Chair:** All right. Is there discussion on Ms Gigantes's suggestion?

**Mr Jackson:** This is awkward, because it took a considerable amount of restraint from several quarters, from large organizations in this province, that knew that Bill 85 was ordered ahead of Mr Martin's bill. There was an effort to cooperate. It would appear, at least from one speaker from the government side, that that spirit of cooperation has now stopped within minutes of completing a rather important bill on adoption.

The piece of legislation which hopefully will be considered by this committee, regardless of how long it has been debated in this province, is timely by virtue of a pretty horrific case before the courts where a criminal potentially stands to gain millions of dollars.

The Ontario Law Reform Commission is studying and is supportive of this, and that'll come out; the minister herself has given guarded support for certain aspects of it, but I think there is a greater issue of fairness and integrity as to how this committee conducts itself. I'll certainly be seeking a recorded vote on this motion. It's cast in the positive. We're asking to affirm the subcommittee recommendation.

I think it's fair that whether it's the French family or the Mahaffy family who are continuing to suffer through their ordeal, that they have publicly asked for the support of Parliament in a non-partisan fashion and that it consider this bill. One week in the life of members of this committee is not a huge sacrifice to call upon them to do. I really do believe that there was a high level of support and understanding, and that was personally conveyed to Mr Martin with his bill that's just been completed and we were pleased to participate in that. It wasn't an easy decision for me to yield my own bill for something when I didn't necessarily have to yield that time.

I am just quite surprised. I'm not surprised to see the letter. If it wasn't done as appropriately, that's fine, but I am rather surprised at the rationale that's been provided, at least by Ms Gigantes. I have indicated to the subcommittee that I believe we should at least meet one day in Ottawa because there are some national victims' rights organizations that are extremely interested in this legislation. That is in your own community, Ms Gigantes, and I would have hoped that we would have had some support from you individually in that regard.

As I say, I will ask for a recorded vote in this matter. The families aren't even aware that this is a problem. They have been notified of the committee's decision of yesterday. I've talked to them.

**Mr McGuinity:** I want to go on record as being in favour of dealing with my colleague's bill during the intercession. I'm not familiar with the specifics of his bill, but I know it treats an important topic. It's one that ought to be subjected to a debate, if we have the time available during intercession. It appears that we do have that time,

so I feel that we should be dealing with this bill during intersession.

Furthermore, it appears that there was some kind of an agreement, informal or otherwise, struck between my colleague and members of the government, and it just seems to me—how would I frame this?—rather unseemly that the government is showing signs of renegeing on this agreement.

**Mr Jackson:** No, one member. That's all we've heard from. It's only one member.

**Mrs O'Neill:** I feel that the intersession is a very important time. I don't think that there is any need for us to wait. We were told by this government that they are not interested in committee meetings during the intersession except for pre-budget consultations. That's the first time I've heard that ruling. In the seven-some years I've been here, we've always worked in January and February. People expect us to be working. This bill has a very high interest and I think it should be on the agenda, and I think it should be on the agenda of this committee.

People have been waiting for this bill, the same as they waited for the adoption bill, but we were and we have been mandated to deal with long-term care, which has taken an awful lot of our time over the last two years, both Bill 101 and Bill 173. These other matters were set aside. It may or may not have been totally necessary to delay them as long as they have, but let's face it: This bill's been around for a long time now.

**Mr Martin:** No comment.

**The Chair:** If I might, the subcommittee did meet yesterday and it did request that I send the letter forward, but I just want to be clear. There is now a motion before the committee that we not meet, because I need a motion if—

**Mrs Gigantes:** I so move.

**The Chair:** Ms Gigantes has so moved. Is there further discussion on that motion? Mr Hope?

**Mr Hope:** No.

**Mrs O'Neill:** There's definitely a request for a recorded vote.

**The Chair:** All those in favour of Ms Gigantes's motion?

**Mrs O'Neill:** I hope that the minutes will refer to—

**Mr Jackson:** Let me just be clear, but I did ask, Mr Chairman. I did ask—

**Mrs Gigantes:** On a point of order, Mr Chair: There's a vote going on.

**Mr Jackson:** No one individual has placed the motion before the committee at the moment, as I understand it.

**Mrs Gigantes:** I have, yes. I have moved the motion.  
1950

**The Chair:** Yes, I asked if Ms Gigantes was placing it as a motion and she then did place it and then I've just asked if there's any discussion on that motion.

**Mr Jackson:** I'm seeking clarification, because I thought we were voting on the motion to support the subcommittee report, which never did get to the full

committee. You advised the committee, but it never voted on the subcommittee report. So now we have a motion not to proceed with the subcommittee report that's not in the minutes.

**The Chair:** I understand, and you ask a good question. The subcommittee asked that I write to the House leaders. I was reporting that to the committee. It was not asking last night for approval or disapproval; it was informing the committee that the subcommittee had asked, as an advisory to the House leaders, that in the intersession we had one bill and that the committee could deal with that during that time.

**Mr Jackson:** Mr Chairman, yesterday, just for my memory peg, the subcommittee members for that committee were yourself, myself—

**The Chair:** Ms O'Neill and Mr O'Connor.

**Mr Jackson:** —and that was our unanimous report that we proceed on that basis.

**The Chair:** It was an advisory to the House leaders. We have received a letter from the—

**Mr Jackson:** I understand that. I'm at odds with someone having a motion not to present a report of the subcommittee, which is rather unusual. I thought the subcommittee's report comes to the table and you vote against it. If Ms Gigantes wants to block—

**Mrs Gigantes:** That was where I started.

**Mr Jackson:** Fair ball. I want to make sure, because I was about to vote, but I thought we're obligated to present the report if we're going to vote on the report. Therefore, someone should table the subcommittee's report. Perhaps Mr O'Connor would like to table the subcommittee report, and then we can vote.

**Mr Hope:** That's why I asked him what was the subcommittee report, because I wasn't about to make a decision—

**The Chair:** But I think the question, though, is, the subcommittee—

**Mr Jackson:** —is obligated to report to this committee and advise in what we're doing.

**The Chair:** We can present that to the committee—

**Mr Jackson:** —and then you can vote against it. Ms Gigantes can vote against it, but the subcommittee has reported in the positive that we proceed with a bill that deals with criminals profiting from their recollections of their crimes. I've been loosely calling this the Bernardo bill, even though he's not been found guilty yet, but that's what this bill is about.

**The Chair:** May I ask then, just to clarify some procedural points, if the clerk would comment at this point.

**Clerk of the Committee (Mr Doug Arnott):** The subcommittee report yesterday was an advisory report. It did not contain a recommendation. It was advisory to this committee. The Chair reported to this committee that the subcommittee had directed the Chair to write to the House leaders requesting authorization of meeting time during the winter. It did not contain a recommendation.

**Mr Jackson:** Just a minute. So nobody objected when the report—I'm sorry to interrupt, Mr Chairman—

**Ms Gigantes:** I did.

**Mr Jackson:** Yesterday you objected.

**Ms Gigantes:** Yes, I did.

**Mr Jackson:** What did you object to yesterday?

**Ms Gigantes:** I objected to the fact that we weren't discussing it, and the Chair recognized that.

**Mrs O'Neill:** I just want to say, Mr Chairman, the reason this has happened is that we are being forced to rise on Thursday. We knew there was a House leaders' meeting today. We were trying to be helpful. We weren't trying to do anything wrong. We were trying to let the House leaders, all our House leaders, know what we were thinking, and we hoped that we would get cooperation. You, certainly, and certainly at our direction, weren't trying to do anything outside the mandate of this committee.

**Ms Gigantes:** Mr Chair, there is a motion that I moved at your request which says that we not recommend to the House leaders that we schedule Bill 85 for the intersession. If that's the way you would like it, Mr Chair, I'll leave it on the table. If not, if it's helpful, I'll withdraw it. But I think we could proceed to vote on that.

**Mr Eddy:** That's a negative motion.

**The Chair:** We have two ways of approaching it. We can vote on the—

**Ms Gigantes:** On the negative motion.

**The Chair:** —negative motion or we can present the subcommittee motion to the committee—

**Mr Hope:** Present the subcommittee's report and let's vote on that.

**The Chair:** —and vote on that. We would then present the subcommittee—

**Ms Gigantes:** I withdraw my motion.

**The Chair:** Okay, withdrawn.

**Ms Gigantes:** We are then prepared to proceed with the other.

**The Chair:** Is there approval for the subcommittee's report—

**Mrs O'Neill:** Recorded vote.

**The Chair:** —recorded vote—to the House leaders that Bill 85 be scheduled for the intersession?

**Mr Jackson:** So moved.

**The Chair:** All those in favour of the subcommittee report?

**Ayes**

Eddy, Jackson, McGuinty, O'Neill (Ottawa-Rideau).

**The Chair:** All those opposed?

**Nays**

Carter, Gigantes, Hope, Jamison, Martin, O'Connor.

**The Chair:** The motion is defeated.

**Mr Jackson:** You have no idea what you've done.

**Ms Gigantes:** I would put forward another motion—I didn't wish to confuse the issue by joining them—that we schedule Bill 85 for the next regular session of this committee in the spring session.

**Mrs O'Neill:** And only you know whether that will happen.

**Ms Gigantes:** That's why I'm putting it forward.

**Mr Jackson:** We will reconvene as a committee once the House reconvenes and we'll start all over again.

**Mr Hope:** On a point of order, Mr Chair: There's a motion on the floor and you have to deal with it.

**The Chair:** The motion has been put—

**Mrs O'Neill:** He can speak to that.

**Mr Hope:** So you're speaking to the motion.

**The Chair:** —and Mr Jackson is speaking to the motion.

**Mr Jackson:** I am seeing politics being played with families who have been put through living hell in this province. I would have assumed that the government had enough common sense and decency to have not played politics with something like this. I'm not offended personally. I mean, we learn in this business that you take your best chances when you're in a minority position as a parliamentarian, but this is manipulative and mean-spirited in the extreme.

Mr Martin, I had assumed, had some modicum of decency when we dealt with these issues, when we worked cooperatively with respect to adoption reform. I was badly, badly misled and so were a lot of families. They've been very supportive and happy that Mr Martin was positioning himself that way.

Mr O'Connor—it's mind-boggling. I feel used, I feel lied to, I feel misrepresented on a matter of parliamentary trust with respect to the conduct of the subcommittee yesterday.

I can't imagine why this government would play politics with this issue when victims' rights groups in this province were unanimous. We're not just talking the families of Kristen French and Leslie Mahaffy; we're talking about many families who've experienced this issue. They have watched profiteering from crime going on, and the stakes and the prices are getting higher.

I want to let the members know as well that when the Attorney General referred my entire bill over to the law reform commission, the law reform commission wrote a very positive response to this bill.

I have said from day one, "Please, Minister Boyd, take the bill, make it your own bill." I don't want the authorship of this, I just want the law to be there. I want the law in place before that trial is completed. We are talking millions of dollars of profiteering of our criminal elements or people who have done some of the most heinous crimes in this province's recorded history.

**2000**

And for now, to just blindside this committee and the families who worked really hard for this bill—I was absent from this committee for a period of time today because I was upstairs, subbed into the justice committee, struggling to overcome the fact that two victims' rights groups want to have an impact on my 125 resolution on victims' rights, Mr Chairman, and I was told by the government, who had worked a deal, that I had less than 12 hours to get all those amendments in place.

Mrs Debbie Mahaffy made a quick phone call to the Liberal member on the committee and to the government

side out of desperate appeal: "Would you please at least allow me to have a voice in the committee report?" Now, we were able to correct that, and Priscilla de Villiers, who was on an airplane to Ottawa, then rushed off to make a call to members in this building in order to plead with them to give her at least one more week to get her information into a report. Now, how am I supposed to go back to these individuals and say, "I know it's only been four hours since I talked to you, but wait till you hear the latest little number that they're doing on you"?"

I can't begin to tell you how many victims' families in this province have felt done in by governments, not just your government or the previous government or the one before that. They've been seeking these reforms for a long time, and why this government is so frightened of one small piece of legislation which the citizens of this province have, quite frankly, highly supported and are looking forward to—don't make it my bill, make it your bill, but let's get on with the reform.

Mr O'Connor, I don't know how you can look people straight in the face after what you said yesterday in this committee.

**Mr O'Connor:** You should ask him why he didn't want to move forward in the summer.

**Ms Gigantes:** Mr Chair, can you please—

**The Chair:** Let Mr Jackson wind up. I have Ms O'Neill and then we'll have to move—

*Interjections.*

**The Chair:** Order, please.

**Mr Jackson:** Long-term care took priority. I've been accused of—why I didn't proceed with it in the summer.

**Mr O'Connor:** In June you had time.

**The Chair:** Order.

**Mr Jackson:** Mr O'Connor, no, we did not have time in June and that's a fact.

**Mrs O'Neill:** I will say that in June we dealt with the Children at Risk report, and that went right till the very end of the session.

One of the problems with this government is that we have had very, very limited sittings. Anybody who's been around Ontario knows that. We've got bills being put through with 18 closure motions and we're being told today—

*Interjection.*

**Mrs O'Neill:** Every single bill this government presented this fall has been time-allocated.

**Ms Gigantes:** It's the only short session we've had since—

**Mrs O'Neill:** I didn't speak when you spoke.

**The Chair:** Order, please. Ms O'Neill has the floor.

**Mrs O'Neill:** I did not speak. The fact of the matter is that we haven't had one new piece of legislation presented this fall sitting. It was designed that way. So we have to sit on our hands and wait until you guys call an election. We can't do anything. The people of Ontario are pretty mad about that and so are we.

I'm telling you that on December 6, 1994, the unanimous consent motion now looks a bit shabby to me from

the government, that they would stand today and talk about women who have been abused and violence that has been portrayed against women, and then come in here today and say they haven't got any interest in this bill, which we all likely will agree to in the end. But the timing of it is crucial.

These families haven't got much to go on over Christmas. Maybe some people have been made happy with Bill 158, so you can be as self-righteous as you want and you can smile and you can use your power. I think you're using it very badly today.

**The Chair:** Any other comments?

**Mr McGuinty:** Just so I'm clear, Mr Chair, does that mean we won't be meeting at all during the intersession?

**The Chair:** There has been no recommendation to meet. There is no matter before us.

**Mr Eddy:** Are there other committees that will? You don't know whether there are other committees that have the opportunity—

**The Chair:** I don't know.

**Mr Eddy:** It seems, when we have the time, it's a waste of time. As Ms O'Neill has pointed out, people expect us to be working. I know we work in our constituencies certainly, but it's more or less perceived as more of a vacation, I think, than working, and they want us working on legislation in the House. That's certainly what I get told time and time again.

I think it's unfortunate. If we have the time, why wouldn't we proceed? Is there a reason why we can't? Is there some reason that we can't decide to proceed with the bill and the hearings?

**Ms Gigantes:** Mr Chair, if I could, maybe Mr Eddy's not aware of the motion on which the discussion is taking place, which is a motion that we inform the House leaders that we'd like to schedule this bill for the spring session as soon as we come back.

**Mrs O'Neill:** That may or may never happen.

**Mr Eddy:** And that will be April. It has been as late as April, hasn't it? It's unfortunate.

**Mrs O'Neill:** We are proroguing and we have no guarantees. There are no guarantees at all when you prorogue, none.

**Mr McGuinty:** Recently, and Ms Gigantes will be aware of this, in Ottawa-Carleton in the context of our municipal elections, our largest local paper conducted a poll to find out what was uppermost in the minds of our constituents. They said that crime was the number one issue.

**Mrs O'Neill:** Exactly.

**Mr McGuinty:** I have a feeling that is a feeling that's fairly widespread throughout the province. Now, if we take that factor, number one—factor number two, I'm not sure about the government members, but I would find it really hard to go into a crowded room in my riding and say, "I'm not sitting in committee between December 8 and the end of March, and possibly later."

**Mrs O'Neill:** Maybe never.

**Mr McGuinty:** I wouldn't want to say that to an

editorial board. I'm not sure whom I'd want to say it to, except maybe my wife and kids. So I think we have a responsibility to use the time that's available to us as wisely as we can. This is not the kind of bill that you would categorize as not having any real purpose, as causing mischief. I think it treats a very important issue that's on the minds of very many Ontarians and I really can't understand why we aren't able to get it in between now and the end of March.

**The Chair:** We have a motion that has been put forward. I'm going to call the motion.

**Ms Gigantes:** A recorded vote.

**The Chair:** A recorded vote. All those in favour of Ms Gigantes's motion?

**Ayes**

Carter, Gigantes, Hope, Jamison, O'Connor.

**The Chair:** All those opposed?

**Nays**

Eddy, Jackson, McGuinty, O'Neill (Ottawa-Rideau).

**The Chair:** I declare the motion carried.

There being no further business before the committee, it stands adjourned until the call of the Chair.

*The committee adjourned at 2007.*





## CONTENTS

Tuesday 6 December 1994

### **Adoption Disclosure Statute Law Amendment Act, 1994, Bill 158, Mr Martin /**

#### **Loi de 1994 modifiant des lois en ce qui concerne la divulgation de renseignements**

<b>sur les adoptions, projet de loi 158, M. Martin</b> .....	S-2627
Willa Marcus .....	S-2627
Frank Rioux .....	S-2629
Ontario Association of Children's Aid Societies .....	S-2630
Sandy Moschenko, manager of accreditation	
Elaine Rutherford, supervisor, adoption disclosure services, Children's Aid Society of Metropolitan Toronto	
Gemma Nicholson, supervisor, adoption disclosure services, Catholic Children's Aid Society of Metropolitan Toronto	

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York-Mackenzie L)
- \***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- \*Carter, Jenny (Peterborough ND)  
Cunningham, Dianne (London North/-Nord PC)
- \*Gigantes, Evelyn, (Ottawa Centre ND)
- \*Jamison, Norm (Norfolk ND)
- \*Martin, Tony (Sault Ste Marie ND)
- \*McGuinty, Dalton (Ottawa South/-Sud L)
- \*O'Connor, Larry (Durham-York ND)
- \*O'Neill, Yvonne (Ottawa-Rideau L)
- Rizzo, Tony (Oakwood ND)
- Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

#### **Substitutions present / Membres remplaçants présents:**

Hope, Randy R. (Chatham-Kent ND) for Mr Rizzo  
Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

#### **Also taking part / Autres participants et participantes:**

Ministry of Community and Social Services:  
Belford, Joan, policy analyst, children's services branch  
Caldcott, John, legal counsel

**Clerk / Greffier:** Arnott, Doug

#### **Staff / Personnel:**

Drummond, Alison, research officer, Legislative Research Service  
Schuh, Cornelia, deputy chief legislative counsel





JUL 5 1995



3 1761 11467176 1